

Case Number:	CM15-0201206		
Date Assigned:	10/16/2015	Date of Injury:	12/18/2012
Decision Date:	11/25/2015	UR Denial Date:	10/07/2015
Priority:	Standard	Application Received:	10/13/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Arizona, California

Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 61 year old male, who sustained an industrial-work injury on 12-18-12. He reported initial complaints of bilateral shoulder pain. The injured worker was diagnosed as having left shoulder tendinopathy, deficient labrum, status post right shoulder arthroscopy, cervical sprain-strain with spondylosis, dyspepsia, anxiety, and depression. Treatment to date has included medication, surgery (right shoulder arthroscopy), and diagnostics. Currently, the injured worker complains of bilateral shoulder pain. Medication reduces the pain by 50% with functional improvement with ADL's (activities of daily living) with the medication versus not taking them at all. Pain is rated 8 out of 10, 4 out of 10 at best, and 10 out of 10 without meds. Meds include Percocet 10-325, Omeprazole, Zoloft, and Ambien. Per the primary physician's progress report (PR-2) on 9-21-15, exam notes limited range of motion in all planes with positive crepitus on circumduction with positive impingement signs of both shoulders. Neck and back exam continue to reveal limited range of motion, motor strength, sensation, and DTR (deep tendon reflexes) otherwise grossly intact in the upper extremities, and heel-toe walk was possible. Current plan of care includes refill of medication. The Request for Authorization requested service to include Percocet 10/325mg #60 and Ambien 10mg #30. The Utilization Review on 10-7-15 denied the request for Percocet 10/325mg #60 and Ambien 10mg #30, per CA MTUS (California Medical Treatment Utilization Schedule), Chronic Pain Medical Treatment Guidelines 2009 and ODG Pain (updated 10/05/15) Online Version Zolpidem (Ambien).

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Percocet 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Opioids for neuropathic pain.

Decision rationale: Percocet is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Norco for several months and currently on Percocet with identifiable change in function and pain level. Previously the claimant was on Tylenol with Norcol, but there was no indication of Tylenol failure alone or weaning failure of opioids. Although, the claimant cannot tolerate NSAIDS, continued use of Percocet is not medically necessary.

Ambien 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain (updated 10/05/15) Online Version Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter and pg 64.

Decision rationale: The MTUS guidelines do not comment on insomnia. According to the ODG guidelines, recommend that treatment be based on the etiology, with the medications. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. Zolpidem is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). In this case, the claimant had used the medication for several months. The etiology of sleep disturbance was due to pain rather than a primary sleep disorder. Continued use of Zolpidem (Ambien) is not medically necessary.