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| Case Number: | CM15-0020273 | | |
| Date Assigned: | 02/09/2015 | Date of Injury: | 05/27/2004 |
| Decision Date: | 03/26/2015 | UR Denial Date: | 01/27/2015 |
| Priority: | Standard | Application Received: | 02/03/2015 |

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 63 year old female who sustained an industrial injury on May 27, 2004. She has reported right shoulder pain and bilateral knee pain and has been diagnosed with knee joint replacement, unspecified disorder of join, shoulder region, and traumatic arthropathy, shoulder region. Treatment has included medications, injections, and a wrist brace. Currently the injured worker had right shoulder abduction limited to 90 degrees, right shoulder flexion was at 90 degrees and was bracing her right wrist. The treatment plan included medication management. A progress report dated January 16, 2015 identifies ongoing pain in the right shoulder. The treatment plant states the medications "were refilled in a stable fashion." On January 27, 2015 Utilization Review non certified Percocet 10/325 mg # 60 without citation.

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: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20, 9792.26 MTUS (Effective July 18, 200.

Decision rationale: Regarding the request for Percocet (oxycodone/acetaminophen), California Pain Medical Treatment Guidelines state that Percocet is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. Additionally, the patient is currently using Suboxone, which is indicated in the treatment of opiate addiction. It is unclear why the patient is being prescribed a short acting opiate pain medication in addition to Suboxone. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Percocet (oxycodone/acetaminophen) is not medically necessary.