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| Case Number: | CM15-0060257 | | |
| Date Assigned: | 04/06/2015 | Date of Injury: | 06/26/2003 |
| Decision Date: | 05/05/2015 | UR Denial Date: | 03/13/2015 |
| Priority: | Standard | Application Received: | 03/30/2015 |

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: Preventive Medicine, Occupational Medicine

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 46 year old male who sustained an industrial injury on 6/26/03 which was cumulative in nature revolving around an overuse repetitive motion injury of his upper extremities associated with work activities. He was felt to have tenosynovitis of the shoulders and right wrist and right lateral epicondylitis. He had physical therapy. Later he carried a diagnosis of right wrist de Quervain's tenosynovitis. He currently complains of persistent sharp pain in the cervical spine and right shoulder. Medications are Maxalt, Paxil, Prilosec, compounded cream, Oxycontin, Percocet, and Xanax. A urine drug test was done 10/20/14. Diagnoses include right wrist de Quervain's release (11/21/03); right fibula fracture, status post (12/28/03); status post open reduction internal fixation of the right ankle (1/15/04); status post right carpal tunnel release (1993); status post C5-6 and C6-7 anterior cervical discectomy and fusion with instrumentation (1/11/11); right shoulder surgery (2/8/12); right shoulder degenerative disease; cervical spondylosis; psychiatric co-morbidity; chronic pain syndrome. Treatments to date include physical therapy, medications, home exercise program. Diagnostics include MRI of the cervical spine (10/10/03) showing possible C4-5, C5-6 disc protrusion; MRI cervical spine (12/3/04, 8/6/10, 5/14/14) showing disc bulge; status post right shoulder subacromial decompression and arthroscopic labral tear (1/3/05). In the progress note dated 10/14/14 the treating provider's plan of care requested refills on Percocet and Soma. There is no documentation of benefits secondary to opioid use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants for pain Page(s): 63-65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29.

Decision rationale: MTUS Guidelines are very clear in the recommendation that Soma is a non-recommended drug. Due to problems with Soma the Guidelines devote a separate section to this drug in addition to the recommendations under muscle relaxants. There are no unusual circumstances to justify an exception to Guidelines. Soma 350g #90 is not medically necessary.

Percocet (Acetaminophen & Oxycodone) 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids /Functional Improvement Measures Page(s): 78-80 and 48.

Decision rationale: For the responsible chronic daily prescribing of opioids MTUS Guidelines have very specific criteria to justify their use. These standards include reasonable detail of pain improvement (amount and length of pain relief) and reasonable details regarding improved function (measured improvements as a result of use). Neither of these standards has been met. The only statements by evaluating physicians are that the medications are not very effective and there is no measures/documentation of its effects on function. Under these circumstances, the Percocet 10/325mg #120 is not supported by Guidelines and is not medically necessary.