

Case Number:	CM14-0148214		
Date Assigned:	09/18/2014	Date of Injury:	01/15/2013
Decision Date:	09/24/2015	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/11/2014

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: Emergency 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 53-year-old female, who sustained an industrial injury on 1-15-2013. She reported right upper extremity pain. Diagnoses have included hand pain, shoulder pain and dizziness and giddiness. Treatment to date has included surgery, cortisone injections, physical therapy and medication. According to the progress report dated 8-13-2014, the injured worker complained of right upper extremity pain. The pain level had decreased since the last visit. She reported that medications were working well. Current medications included Cymbalta, Percocet and Naprosyn. Exam of the right shoulder revealed tenderness to palpation in the biceps groove. Exam of the right wrist revealed restricted range of motion and tenderness to palpation over the radial side. Authorization was requested for Percocet.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 5/325mg, #90: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82; Opioid Dosing, Page 86.

Decision rationale: The requested Percocet 5/325mg, #90 is medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures; and Opioid Dosing, Page 86, note "In general, the total daily dose of opioid should not exceed 120 mg oral morphine equivalents." The injured worker has right upper extremity pain. The pain level had decreased since the last visit. She reported that medications were working well. Current medications included Cymbalta, Percocet and Naprosyn. Exam of the right shoulder revealed tenderness to palpation in the biceps groove. Exam of the right wrist revealed restricted range of motion and tenderness to palpation over the radial side. The treating physician has documented functional stability from this low opiate load narcotic. The criteria noted above having been met, Percocet 5/325mg, #90 is medically necessary.