

Case Number:	CM13-0009594		
Date Assigned:	11/08/2013	Date of Injury:	06/12/2009
Decision Date:	01/21/2014	UR Denial Date:	07/31/2013
Priority:	Standard	Application Received:	08/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 underlying date of injury in this case is 06/12/2009. The primary diagnosis is chronic pain. A treating physician progress note of 07/01/2013 notes that the patient has the diagnosis of bilateral shoulder pain, right-hand numbness, neck pain, low back pain, and altered depression/insomnia. The treating physician notes that with pain medication the patient has pain of 0/10 and without it is 3-7/10. The provider notes that opioid medication allows the patient to perform activities of daily living and that the patient denies side effects or aberrant behavior and that the patient only receives treatment through that physician's office. The physician noted the patient was not permanent and stationary since he had left shoulder surgery 11/15/2012. The physician requested continuation of Vicodin b.i.d. as needed for pain. An initial physician review recommended modification of the request for Vicodin for weaning purposes, noting that the continued use of this medication is not indicated without evidence that the patient is working and continues to improve in pain and function. This note indicates the patient continued to be temporary total disabled, but there was no specific documentation of functional benefit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vicodin on tablet two times a day (BID): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids/Ongoing Management Page(s): 78.

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on Opioids/Ongoing Pain Management, page 78, recommends "Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects...Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids...Information from family members or other caregivers should be considered in determining the patient's response to treatment." I note as well that the definition section of the California Medical Treatment Utilization Schedule Section 92.20, page 1, states, "Functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam performed and documented." In this case, the medical records do not document functional benefit consistent with these guidelines. The medical records document a general discussion of subjective functional improvement without specific measureable or verifiable items per the treatment guidelines. Moreover, it is not clear that the dose has been titrated to the lowest possible dose to maintain function. Additionally there appears to be inconsistencies in the medical record since the patient reports a 0/10 pain with medication yet it is unclear at that level why the patient continues to have the degree of restrictions which have been applied. Overall, the 4 domains of opioid management have not been documented consistent with the treatment guidelines. This request is not medically necessary.