

Case Number:	CM13-0034681		
Date Assigned:	12/11/2013	Date of Injury:	06/21/2002
Decision Date:	04/23/2014	UR Denial Date:	10/06/2013
Priority:	Standard	Application Received:	10/16/2013

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas. 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/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 patient is a 53-year-old female who sustained an unspecified injury on 06/21/2002. The patient was evaluated on 09/09/2013 for complaints of bilateral shoulder pain and popping in certain positions. The documentation submitted for review noted that the patient had an injection in her shoulder on 05/17/2013, which helped her. The documentation noted that the patient gets muscle spasms in the shoulder blade area and the medications helped. The documentation submitted for review indicated that the patient had difficulty with taking a shower, a bath, washing and drying her body and face, turning on an off faucets, getting on and off the toilet, brushing and combing her hair, dressing herself, putting on and off shoes and socks, or opening a carton of milk. The physical examination objective findings were noted as bilateral shoulder range of motion of flexion 140/180 degrees, abduction 120/180 degrees, external rotation 60/90 degrees, and internal rotation 45/90 degrees. The documentation further noted that the patient was positive for crepitus, impingement test, and there was tenderness of the SITS muscles. The treatment plan indicated the continuation of use of hydrocodone 10/325 mg and cyclobenzaprine 7.5 mg

IMR ISSUES, DECISIONS AND RATIONALES

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

HYDROCODONE 10/325: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-79.

Decision rationale: The documentation submitted for review did not indicate that the patient had pain upon evaluation on 09/09/2013. Furthermore, the documentation submitted for review did not indicate the patient had any analgesic effect with the medication. The documentation did not address the patient's pain using the visual analog scale (VAS) with and without the use of medication. The Chronic Pain Guidelines recommend the ongoing monitoring of opioid therapy to include the analgesic effect. The guidelines additionally indicate that patients should be monitored for improvement in functional ability. The documentation submitted for review did not indicate that the patient had any functional improvement. The guidelines recommend discontinuing opioids if there is no overall improvement in function. Therefore, the continued use of the medication is not supported. It is additionally noted that the request does not specify the number of the medication being requested. The amount is needed to ensure the patient is being properly monitored and to modify treatment, should the efficacy of the medication come into question. Given the information submitted for review, the request for hydrocodone 10/325 mg is non-certified.

FEXMID 7.5 mg:

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-64.

Decision rationale: The documentation submitted for review did not indicate the patient's pain level using the visual analog scale (VAS). The documentation submitted for review indicated that the patient had occasional muscle spasms in the shoulder blade area. The Chronic Pain Guidelines recommend the use of muscle relaxants to be used with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic lower back pain. The documentation submitted for review did not indicate that the patient had low back pain. Therefore, the use of the medication is not supported. Furthermore, the documentation submitted for review did not indicate that the patient had pain using the visual analog scale or the efficacy of the medication. It is additionally noted the amount of medication being requested was not submitted for review. The amount is needed to ensure the patient is being properly monitored and to modify treatment should the efficacy of the medication come into question. Given the information submitted for review, the request for Fexmid 7.5 is non-certified.