

Case Number:	CM14-0000260		
Date Assigned:	01/10/2014	Date of Injury:	11/08/2011
Decision Date:	06/11/2014	UR Denial Date:	12/18/2013
Priority:	Standard	Application Received:	01/02/2014

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. The expert 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 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 injured worker is a 52-year-old male who reported an injury on 01/08/2011, after being struck by a truck. Current diagnoses include left shoulder severe adhesive capsulitis, status post rotator cuff repair in 03/2012, status post 2 manipulations under anesthesia, residual bursitis/impingement, and right carpal tunnel syndrome. The injured worker was evaluated on 12/12/2013. The injured worker reported 6/10 left shoulder/upper extremity pain. The injured worker reported no improvement in symptoms following a corticoid steroid injection provided on 10/25/2013. The injured worker has also participated in physical therapy and a home exercise program. Physical examination revealed limited range of motion, positive tenderness in the AC joint with cross arm testing and direct palpation, positive subacromial bursitis, positive impingement, and 4/5 strength. X-rays obtained on 10/25/2013 indicated moderate glenohumeral and AC degenerative joint disease. Treatment recommendations at that time included continuation of current medication, including Norco 10/325 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

MEDICATION-HYDROCODONE/APAP (90 TABS): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: Chronic Pain Medical Guidelines Treatment state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has utilized Norco 10/325 mg since 05/2013. There is no evidence of objective functional improvement. There is also no strength or frequency listed in the current request. Therefore, the request is not medically necessary.