

Case Number:	CM14-0003445		
Date Assigned:	01/31/2014	Date of Injury:	02/15/2013
Decision Date:	06/09/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	01/08/2014

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 Illinois. 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 56 year old male who reported an injury on 02/15/2013 due to an unknown mechanism. The clinical note dated 08/12/2013 presented the injured worker with left shoulder and tricep aching, burning, occasionally sharp, and stabbing pain that varies with intensity, and is present all the time. There was also complaints of tightness, stiffness, and weakness. The left shoulder physical exam reported that the range of motion forward flexion was 131 degrees, external rotation was 32 degrees, abduction was 75 degrees, internal rotation behind his back to L4-5 was 30 degrees, and a positive Neer and Hawkins sign. The provider assisted with giving the injured worker a home exercise program. The request for authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

HYDROCODONE 10/325MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Pain Treatment Agreement Page(s): 89.

Decision rationale: The request for Hydrocodone 10/325MG is not medically necessary. The California MTUS guidelines recommend providing ongoing education on both the benefits and limitations of opioid treatment. The guidelines recommend the lowest possible dose should be prescribed to improve pain and function. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The documentation lacks evidence of this medication providing desired effects for the injured worker. There was a lack of an adequate and complete pain assessment within the documentation. The request also does not specify a quantity. Therefore, the request is not medically necessary.