MAXIMUS Federal Services

Case Number:	CM14-0126161		
Date Assigned:	08/13/2014	Date of Injury:	07/26/1994
Decision Date:	09/25/2014	UR Denial Date:	07/07/2014
Priority:	Standard	Application Received:	08/08/2014

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 Occupational Medicine 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:

This is a 60 year old male with a 7/26/94 date of injury, when he injured his right shoulder while cleaning the floor. The patient underwent total shoulder arthroplasty on 8/16/07. The patient was seen on 5/7/14 with complaints of chronic, aching, and constant right shoulder pain. The pain was aggravated with movement and alleviated with medications, ice, heat, sitting and lying down the shoulder. The pain was 5/10 at the best, 10/10 at the worse and 7/10 at night, causing sleeplessness. Exam findings of the right shoulder revealed well-healed incision from the surgery, moderate tenderness to palpation in the acromion, no clavicle or bicipital groove tenderness. The range of motion was: abduction 140 degrees, anterior flexion 130 degrees, extension 45 degrees, external rotation 40 degrees, internal rotation 35 degrees and adduction 35 degrees. The grasp was rated 5/5. The progress note stated that Norco allowed the patient to complete his ADLs with relative release. The diagnosis is adhesive capsulitis of the shoulder, status post shoulder joint replacement. Treatment to date: injections to the shoulder, cold/heat patch, work restrictions and medications. An adverse determination was received on 7/3/14 given that the patient has been prescribed Hydrocodone since 07/13 and that there was a lack of documentation indicating the weaning of the medication or discussion of response to the treatment or any aberrant drug behavior.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 10325mg Qty: 180 day supply 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opiates Page(s): 78-81.

Decision rationale: The MTUS Chronic Pain Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The UR decision dated 7/3/14 indicated that the patient was using Hydrocodone at least from 07/13. However, given the 1994 date of injury, the duration of opiate use to date is not clear. There is no discussion regarding non-opiate means of pain control, or endpoints of treatment. The records do not clearly reflect continued analgesia, continued functional benefit, a lack of adverse side effects, or aberrant behavior. Although opiates may be appropriate, additional information would be necessary, as the MTUS Chronic Pain Guidelines require clear and concise documentation for ongoing management. Therefore, the request is not medically necessary and appropriate.