

Case Number:	CM14-0126295		
Date Assigned:	08/13/2014	Date of Injury:	11/30/2004
Decision Date:	09/16/2014	UR Denial Date:	07/30/2014
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 Anesthesiology, has a subspecialty in Pain Medicine 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 injured worker is a 49 year old male injured on 11/30/04 due to undisclosed mechanism of injury. Diagnoses included osteoarthritis of the knee, sprain of knee and leg, current tear of medial cartilage and/or meniscus of knee, disorder of shoulder, glenoid labrum detachment, subacromial bursitis, primary arthritis of shoulder, displacement of lumbar intervertebral disc without myopathy, closed dislocation shoulder, and neck sprain. The injured worker underwent right shoulder surgical intervention on 12/09/11. Clinical note dated 01/29/14 indicated the injured worker presented complaining of mild to moderate bilateral shoulder pain. The injured worker reported recent increased activity and pushing of function. The injured worker continued to utilize Ketoprofen and continued to complain of numbness. The injured worker reported resting with knee rehab and utilizing crutches which caused pain, left greater than right. Clinical note dated 05/02/14 indicated the injured worker requested prescription refills for hydrocodone, Ketoprofen, and Dexilant. The injured worker reported inability to obtain good night sleep due to pain. Medications included hydrocodone 10-325mg one to two tablets every six hours PRN, Dexilant 60mg DR one capsule QD, and Ketoprofen gel 20% BID. The initial request for Hydrocodone/APAP 10/325 #120 was non-certified on 07/30/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 10/325 #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Specific examples of improved functionality should be provided to include individual activities of daily living, community activities, and exercise able to perform as a result of medication use. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Hydrocodone/APAP 10/325 #120 cannot be established at this time.