

<b>Case Number:</b>	CM14-0158276		
<b>Date Assigned:</b>	10/01/2014	<b>Date of Injury:</b>	01/02/2014
<b>Decision Date:</b>	10/30/2014	<b>UR Denial Date:</b>	08/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/26/2014

### 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, has a subspecialty in Pain Management 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 male patient with the date of injury of January 2, 2014. A Utilization Review was performed on August 26, 2014 and recommended modification of 1 prescription of Hydrocodone 10/325mg to 1 prescription of Hydrocodone 10/325mg up to #68 between 8/14/2014 and 10/24/2014 and non-certification of 1 pain management between 8/15/2014 and 10/24/2014 and 1 injection 1cc depo-medrol, 5cc 1% xylocaine, 2cc of 0.5% Marcaine to left shoulder between 8/15/2014 and 8/15/2014. A Progress Report dated August 15, 2014 identifies Subjective Complaints of increased neck pain and bilateral shoulder pain. Objective Findings identify diffuse tenderness with limited range of motion in the cervical spine. Positive foramen compression test on the right. Positive Spurling's test bilaterally. Examination of the bilateral shoulders reveals positive Hawkins test, bilaterally with left side greater than right. Positive Neer test on the left. 4/5 supraspinatus strength test with increased pain on the left. Diagnoses identify cervicothoracic strain/arthrosis/discopathy with central and foraminal stenosis and resultant cephalgia, bilateral shoulder impingement syndrome with possible rotator cuff tears, possible bilateral carpal tunnel and/or cubital tunnel syndromes, psychiatric complaints, and sleep disturbance secondary to pain. Treatment Plan identifies Hydrocodone 10/325 mg by mouth 3 times a day when necessary pain, authorization for referral for pain medication dispensing, and the patient was given 1 cc of Depo-Medrol, 5 cc of 1% Xylocaine and 2 cc of 0.5% Marcaine injection to the left shoulder subacromial space.

### 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.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 47, 75-79, 120.

**Decision rationale:** Regarding the request for Hydrocodone, California Pain Medical Treatment Guidelines state that Hydrocodone is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Hydrocodone is not medically necessary.

**1 PAIN MANAGEMENT:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Independent Medical Examinations and Consultations Chapter, Page 127 State of Colorado, Chronic Pain Disorder Medical Treatment Guidelines, Exhibit Page Number 52

**Decision rationale:** Regarding the request for 1 pain management, California MTUS does not address this issue. ACOEM supports consultation if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Within the documentation available for review, the patient has increased pain in the cervical spine and shoulders. Additionally, the treating physician is having difficulty supporting the medical necessity for opiate pain medication. He has requested pain management to address medication issues. Using a pain management specialist to better document the medical necessity of any pain medications seems to be a reasonable next treatment option. Therefore, the currently requested pain management consultation is medically necessary.

**1 INJECTION 1 CC DEPO-MEDROL, 5 CC 1% XYLOCAINE, 2 CC OF 0.5 % MARCAINE TO LEFT SHOULDER:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder

**Decision rationale:** Regarding the request for 1 injection 1cc depo-medrol, 5cc 1% xylocaine, 2cc of 0.5% Marcaine to left shoulder, Chronic Pain Medical Treatment Guidelines support the use of a subacromial injection if pain with elevation significantly limits activity following failure of conservative treatment for 2 or 3 weeks. They go on to recommend the total number of injections should be limited to 3 per episode, allowing for assessment of benefits between injections. Official Disability Guidelines recommend performing shoulder injections guided by anatomical landmarks alone. Guidelines go on support the use of corticosteroid injections for adhesive capsulitis, impingement syndrome, or rotator cuff problems which are not controlled adequately by conservative treatment after at least 3 months, when pain interferes with functional activities. Guidelines state that a 2nd injection is not recommended if the 1st has resulted in complete resolution of symptoms, or if there has been no response. Within the documentation available for review, it is unclear if the patient has failed conservative treatment directed at the shoulder for 2 or 3 weeks. There is no mention of significantly limited activity. As such, the currently requested 1 injection 1cc depo-medrol, 5cc 1% xylocaine, 2cc of 0.5% Marcaine to left shoulder is not medically necessary.