

<b>Case Number:</b>	CM14-0164767		
<b>Date Assigned:</b>	10/09/2014	<b>Date of Injury:</b>	09/17/2013
<b>Decision Date:</b>	11/10/2014	<b>UR Denial Date:</b>	09/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2014

### 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 & Rehabilitation, has a subspecialty in Interventional Spine 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 patient is a 65 years old male with an injury date on 09/17/2013. Based on the 08/28/2014 progress report provided by [REDACTED], the diagnoses are: 1. Bilateral CTS 2. SP fracture left humerus. According to this report, the patient is status post left shoulder 2013 "failed surgery and did not help her pain." The shoulder is frozen in certain area. Range of motion is restricted in all planes. Decrease grip strength is noted bilaterally. The patient is unable to hold, grip or grasp anything on weight and is unable to reach overhead or reach behind her back. The 07/22/2014 report indicates shoulder pain is "now worse than before." The 06/20/2014 report indications pain level is at a 7/10 without medications and 3-4/10 with medication. Patient's subjective and objective findings were not included in the 06/20/2014, 07/22/2014, and 08/28/2014 reports for review. An EMG study of the upper limb conducted performs on 02/03/2014 with normal impression. There were no other significant findings noted on this report. The utilization review denied the request on 09/10/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 03/04/2014 to 08/28/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg, one by mouth three times per day, #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone (Vicodin, Lortab).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Medical Treatment Guidelines, Medications for chronic pain; Criteria for use of Opioids Pag.

**Decision rationale:** According to the 08/28/2014 report by [REDACTED] this patient presents with left shoulder pain that is "frozen in certain area." The treater is requesting Norco 10/325mg, #90. Norco was first mentioned in the 03/18/14 report; it is unknown exactly when the patient initially started taking this medication. For chronic opiate use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Review of report shows documentation of pain assessment using a numerical scale describing the patient's pain. However, no outcome measures are provided; No aberrant drug seeking behavior is discussed, and no discussion regarding side effects. No specific ADL's and opiate monitoring such as urine toxicology are discussed. Given the lack of sufficient documentation demonstrating efficacy from chronic opiate use, the patient should be slowly weaned as outlined in MTUS Guidelines. The request is not medically necessary.

**MRI of left humerus:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 207-208. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter: Magnetic resonance imaging (MRI)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chapter under MRI

**Decision rationale:** According to the 08/28/2014 report by [REDACTED] this patient presents with left shoulder pain that is "frozen in certain area." The treater is requesting an update MRI of left humerus. Report of prior MRI was not included in the file for review; date of study and result are unknown. Regarding MRI, the ODG guidelines state "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology." Review of the reports show that the patient's left shoulder pain has worsened and decreased strength is noted. The patient had a "failed" shoulder surgery in 2013 and continues to be symptomatic. Given that the patient continue to be symptomatic after the surgery, the requested updated MRI of the left shoulder appears reasonable. The request is medically necessary.

**CT of the left humerus:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter: CT Arthrography

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder chapter under CT scan

**Decision rationale:** According to the 08/28/2014 report by [REDACTED] this patient presents with left shoulder pain that is "frozen in certain area." The treater is requesting a CT of the left humerus. The utilization review denial letter states "If the absence of progressive objective functional deficits, imaging would not be recommended. Furthermore, in the absence of red flag or an increase in functional deficit or a new symptomatology, advanced imaging is not warranted." Regarding computer tomography, ODG recommended if there a suspected tear of labrum, full thickness rotator cuff tear or SLAP tear, recurrent instability, or a proximal humeral fracture. In this case, the patient does not present with a suspected tear of labrum, full thickness rotator cuff tear or SLAP tear, recurrent instability, or a proximal humeral fracture to warrant the image study. Furthermore, there were no discussions provided as to why the patient needed CT scan of the left humerus. MRI is being recommended which is a superior imaging for soft tissue. The treater does not provide suspicion for proximal humeral fracture that may have been missed on X-ray. The request is not medically necessary.