

Case Number:	CM14-0071058		
Date Assigned:	07/14/2014	Date of Injury:	06/15/2012
Decision Date:	09/22/2014	UR Denial Date:	05/09/2014
Priority:	Standard	Application Received:	05/16/2014

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 42 year old male who reported an injury to his left shoulder. The utilization review dated 07/23/14 resulted in modified approvals for Oxycontin and Dilaudid and denial for Soma. A clinical note dated 08/20/13 indicated the injured worker was complaining of left shoulder pain and utilized Soma and Dilaudid and Percocet for pain relief. Upon exam, he demonstrated 75 degrees of abduction, 90 degrees of flexion, and 4+/5 strength with external rotation. A clinical note dated 09/19/13 indicated the he was still complaining of left shoulder pain. He had rotator cuff involvement as well. He had symptoms associated with frozen shoulder. A clinical note dated 04/28/14 indicated he previously undergoing hemiarthroplasty at the left shoulder. He demonstrated 170 degrees of flexion with 40 degrees of external rotation. Rotator cuff strength was good. Pain was elicited with testing at the supraspinatus.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 30mg Qty: 240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 92.

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

Decision rationale: According to the guidelines, injured workers 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. 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 request for Oxycodone 30mg Qty 240 is not medically necessary.

Dilaudid 4mg Qty: 100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51, 54, 55, 74, 75, 93.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydromorphone (Dilaudid) Page(s): 51.

Decision rationale: According to the guidelines, injured workers 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. 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 request for Dilaudid 4mg Qty 100 is not medically necessary.

Soma 350mg Qty: 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24, 29, 65, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 65.

Decision rationale: According to the guidelines, Soma is not recommended for long-term use. This medication is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy. The documentation indicates that the injured worker is being prescribed the medication for chronic pain and long-term care exceeding the recommended treatment window. As such, this request for Soma 350mg Qty 90 is not medically necessary.