

Case Number:	CM14-0092765		
Date Assigned:	07/25/2014	Date of Injury:	03/14/2008
Decision Date:	11/03/2014	UR Denial Date:	06/09/2014
Priority:	Standard	Application Received:	06/19/2014

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, 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 injured worker is a 42-year-old female who was reportedly injured on 3/14/2008. The request for authorization noted the diagnosis as internal derangement and impingement syndrome of the bilateral shoulders. The most recent progress note, dated June 16, 2014, indicated that there were ongoing complaints of bilateral shoulder pain. The pain level was noted to be 8/10. The physical examination identified a 5'9", 200 pound normotensive (122/71) individual who is noted to be in no acute distress. Bilateral shoulders had surgical scars present, and the left shoulder range of motion restricted in all directions. Lumbar range of motion was restricted by pain in all directions. Left shoulder had a positive impingement sign. Muscle strength was 5/5 in all limbs. No recent diagnostic studies are available for review notes. Previous treatment included surgery, medication, and conservative treatment. A request was made for ibuprofen 600 mg #60 with 3 refills and Norco 10/325 mg #120 and was not certified in the pre-authorization process on 6/9/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen 600mg 1 tablet twice a day, # 60, with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs Page(s): 70, 71, 72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 22.

Decision rationale: As outlined in the MTUS, this is a nonselective, non-steroidal anti-inflammatory medication which has an indication for chronic low back pain. The physical examination noted chronic low back pain. However, the narrative in the progress note reported a "40% decrease of the patient's inflammatory pain" without any objective data to support that declaration. Furthermore, when noting the bilateral shoulder surgery and the current physical examination parameters described there are ongoing impingement signs. Given all of the cautions for the use of this medication (side effect profile) identified in the literature and the lack of discussion relative to side effects such as cardiovascular events, gastrointestinal distress; the clinical data presented does not establish the efficacy of the patch, its utility or need for future use of this medication as well as the medical necessity of this medication. With this, the request is not medically necessary.

Norco 10/325mg, 1 four times a day, # 120, with no refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91, 78-80, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) . Page(s): 74-78, 88, 91.

Decision rationale: Norco (hydrocodone/acetaminophen) is a short acting opiate indicated for the management in controlling moderate to severe pain. This medication is often used for intermittent or breakthrough pain. However, as requested the medication is being established as a routine 4 times a day medication, clearly not the prn indication for breakthrough pain. Furthermore, the physical examination noted a decreased range of motion but no significant functional improvement or decrease in pain complaints was reported establishing the efficacy of this medication. Additionally, the progress note did not discuss what objective parameters are noted. While noting a declaration of the pain level to be 10/10 to 5/10; there is no objective data supporting that assertion. There is no objective occasion of the efficacy of this indefinite use or chronic use of this opioid based on the physical examination reported on June 16, 2014. This request is not medically necessary.