

Case Number:	CM14-0189842		
Date Assigned:	11/21/2014	Date of Injury:	08/24/2004
Decision Date:	01/08/2015	UR Denial Date:	11/06/2014
Priority:	Standard	Application Received:	11/13/2014

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 Emergency Medicine, 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:

Patient with reported date of injury on 8/24/2004. No mechanism of injury was documented. Diagnosis are reported as post revision of R shoulder surgery with rotator cuff repair, post R wrist fusion with distal radius bone grafting, bilateral forearm tendinitis and trapezius, paracervical and parascapular strain. Medical reports reviewed. Last report available until 9/30/14. Patient complains of pains to both shoulders radiating to arms. Numbness to L 3rd, 4th and 5th finger numbness. Patient had R supra scapular nerve block on 1/15/14 and 6/18/14 with documented improvement in pain and function. Patient was reportedly approved for radiofrequency ablation of right supra scapular nerve. Medications reportedly improves pain from 6-8/10 to 3/10 and improves mobility and ability to function. No risk or abuse or side effects. Objective exam reveals R arm in sling with limited range of motion. Operative note dated 9/17/14 reports that radio frequency neurotomy was completed on 9/17/14. Urine Drug Screen on 6/30/14 was appropriate. Medications include Cyclobenzaprine, Vicoprofen 7.5/200, Ibuprofen and hydrocodone/acetaminophen. Independent Medical Review is for Urine Drug Screen, Radiofrequency ablation of right supra scapular nerve, "outpatient facility" and hydrocodone/acetaminophen 7.5/300mg #60. Prior UR on 11/6/14 recommended non-certification. It modified Norco to #36.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine drug screen: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Acute and Chronic)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: As per MTUS Chronic pain guidelines, drug screening may be appropriate as part of the drug monitoring process. There is no concern for abuse. Patient had a recent urine drug screen done on 6/30/14 which was appropriate. A repeat UDS with no concern for abuse or documented rationale is not medically recommended. Urine Toxicology Screen is not medically necessary.

Radiofrequency ablation of the right suprascapular nerve: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Radiofrequency of suprascapular nerve

Decision rationale: As per operative note dated 9/17/14, patient already had this procedure done. This is a repeat or duplicate request and is not medically necessary.

Outpatient facility: Upheld

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 Official Disability Guidelines (ODG) Shoulder, Radiofrequency of suprascapular nerve

Decision rationale: As per operative note dated 9/17/14, patient already had this procedure done. This is a repeat or duplicate request and is not medically necessary.

Hydrocodone 7.5mg/Acetaminophen 300mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76.

Decision rationale: This medication contains acetaminophen and hydrocodone, an opioid. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Patient has appropriate documentation of improvement in pain and function with opioid therapy. There is appropriate documentation of monitoring. However, patient appears to also be on Vicoprofen which also contains Hydrocodone. It is unclear why patient is on 2 different medications which contains hydrocodone leading to concern about claims of improvement on "sparring use" of medications and effectiveness of this prescription. Patient is also post-radiofrequency procedure which is supposed to have improved pain by up to 60%. Hydrocodone/Acetaminophen is not medically necessary.