

<b>Case Number:</b>	CM15-0003655		
<b>Date Assigned:</b>	01/15/2015	<b>Date of Injury:</b>	08/16/2009
<b>Decision Date:</b>	03/23/2015	<b>UR Denial Date:</b>	12/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 56-year-old male who reported an injury on 08/16/2009 due to an unspecified mechanism of injury. On 12/09/2014, he presented for a followup evaluation. His complaints included right shoulder and neck pain on the right. He stated that his symptoms had been relatively stable. His medications included ibuprofen 800 mg 3 times a day, oxycodone 180 mg daily, Soma, and hydrocodone 100 mg daily. It was noted that he was functional on his medications, and worked on a full time basis without restrictions. A physical examination showed a VAS score of 5/10. He had discomfort with attempting to put his hand on the back of his head or hand in the middle in the back. He also had some tenderness over the anterior shoulder, but no AC joint tenderness. He was diagnosed with internal disruption of the right shoulder. His medications were refilled at the date of the visit. The treatment plan was for oxycodone IR 30 mg #180, ibuprofen 800 mg #90, and Norco 10/325 mg #200. The rationale for treatment was to continue to alleviate the injured worker's pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone IR 30mg, #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management, Oxycodone. Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management. Page(s): 78.

**Decision rationale:** According to the California MTUS Guidelines, an ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be performed during opioid therapy. Based on the clinical documentation submitted, the injured worker was noted to be getting relief with his medications and was able to work full time. However, there is a lack of documentation showing a quantitative decrease in pain with the use of this medication. Also, no official urine drug screens or CURES reports were provided for review to validate that he has been compliant with his medication regimen. Furthermore, the frequency of the medication was not stated within the request. Therefore, the requested medication is not supported. As such, the request is not medically necessary.

**Norco 10/325, #200:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management, Norco Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management..

**Decision rationale:** According to the California MTUS Guidelines, an ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be performed during opioid therapy. Based on the clinical documentation submitted, the injured worker was noted to be getting relief with his medications and was able to work full time. However, there is a lack of documentation showing a quantitative decrease in pain with the use of this medication. Also, no official urine drug screens or CURES reports were provided for review to validate that he has been compliant with his medication regimen. Furthermore, the frequency of the medication was not stated within the request. Therefore, the requested medication is not supported. As such, the request is not medically necessary.

**Ibuprofen 800mg, #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Inflammatory Medications, Ibuprofen. Page(s): 22.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

**Decision rationale:** According to the California MTUS Guidelines, NSAIDs are recommended for the short term symptomatic relief of low back pain or osteoarthritis and tendinitis. Based on the clinical documentation submitted for review, the injured worker was noted to be receiving relief with his medications. However, there is a lack of documentation showing a quantitative

decrease in pain with the use of this medication to support its continuation. Also, it is unclear how long the injured worker has been using ibuprofen for treatment, and without this information, a continuation would not be supported as it is only recommended for short term use. Also, the frequency of the medication was not provided within the request. In the absence of this information, the request would not be supported. As such, the request is not medically necessary.