

Case Number:	CM15-0198388		
Date Assigned:	10/13/2015	Date of Injury:	07/27/2004
Decision Date:	11/24/2015	UR Denial Date:	10/01/2015
Priority:	Standard	Application Received:	10/08/2015

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
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 65 year old male, who sustained an industrial injury on 07-27-2004. The injured worker was diagnosed as having shoulder pain - right and insomnia secondary to chronic pain. On medical records dated 07-01-2015, the subjective complaints were noted as bilateral shoulder pain. Objective findings were noted as having pain when lifting right arm above the level of the horizontal. Neurovascular into the right hand is intact and normal. Treatments to date included medications. Current medications were listed as Aspirin, Budesonide160-Formoter, Guaifenesin, Atorvastatin Calcium, Colace, Albuterol, Fluticasone Propionate and Flurazepam. The provider was noted to have renewed a prescription for Hydrocodone Bitartrate - Acetaminophen. The injured worker was noted to be on Norco since at least 10-2006. The Utilization Review (UR) was dated 10-01-2015. A Request for Authorization was dated 07-01-2015 for Retro Hydrocodone-APAP 10-325mg #240 DOS 7-1-2015. The UR submitted for this medical review indicated that the request for Retro Hydrocodone-APAP 10- 325mg #240 DOS 7-1-2015 was modified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Hydrocodone/APAP 10/325mg #240 DOS 7/1/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Weaning of Medications.

Decision rationale: The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. In this case, the injured worker has been prescribed opioid medications for years without continued documentation of pain relief, functional improvement, monitoring of adverse effects and/or aberrant behaviors. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment. The request for retro Hydrocodone/APAP 10/325mg #240 DOS 7/1/2015 is determined to not be medically necessary.