

<b>Case Number:</b>	CM15-0221362		
<b>Date Assigned:</b>	11/16/2015	<b>Date of Injury:</b>	01/29/2009
<b>Decision Date:</b>	12/29/2015	<b>UR Denial Date:</b>	11/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/10/2015

### 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: North Carolina, Georgia  
Certification(s)/Specialty: Family Practice

### 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 64 year old male who sustained an industrial injury on 1-29-2009. A review of medical records indicates the injured worker is being treated for left shoulder status post arthroscopic subacromial decompression and rotator cuff repair with subsequent open repair and possible recurrent tear and possible deltoid injury, right shoulder status post arthroscopic subacromial decompression rotator cuff repair. Probable bilateral carpal tunnel and or cubital tunnel syndromes, status post previous right carpal tunnel release, lumbosacral strain, arthrosis, discopathy with central and foraminal stenosis, and bilateral hip arthrosis, right more severe than left. Medical records dated 10-14-2015 noted left shoulder pain. Pain scale was unavailable. Physical examination noted limited range of motion in all directions to the left shoulder. The same was true on the right but the left shoulder motion was much less. He had supraspinatus weakness on his left. Treatment has included Tylenol # 3 since at least 7-8-2015. Utilization review form dated 11-6-2015 modified Tylenol-Codeine 300-30mg from #60 to #40.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tylenol/Codeine 300/30mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain.

**Decision rationale:** CA MTUS allows for the use of opioid medication, such as Tylenol/codeine, for the management of chronic pain and outlines clearly the documentation that would support the need for ongoing use of an opioid. These steps include documenting pain and functional improvement using validated measures at 6 months intervals, documenting the presence or absence of any adverse effects, documenting the efficacy of any other treatments and of any other medications used in pain treatment. The medical record in this case does not use any validated method of recording the response of pain to the opioid medication or of documenting any functional improvement. It does not address the efficacy of concomitant medication therapy. The record does not support medical necessity of ongoing opioid therapy with Tylenol/codeine 300/30 mg # 60, therefore is not medically necessary.