

Case Number:	CM15-0032802		
Date Assigned:	02/26/2015	Date of Injury:	10/31/2011
Decision Date:	04/08/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	02/23/2015

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 55-year-old female who reported an injury on 10/31/2011. The mechanism of injury was the injured worker went to sit in a chair, the chair broke and the injured worker grabbed the desk with her right hand and twisted to the left. The injured worker underwent a left knee total replacement, and a right carpal tunnel release in 10/2013 and physical therapy. The documentation of 01/13/2015 revealed the injured worker had right shoulder pain, right wrist pain, and left knee pain. The injured worker had protracted scapular winging with the right shoulder. The posture was asymmetrical on the right shoulder. The injured worker had maximum tenderness on the anterolateral bursa and the biceps tendon. The injured worker had a positive O'Brien's, Speed's test, Yergasson's, and modified throwing O'Brien's, Hawkins test, cross body test and belly press. The injured worker had limiting factors of pain with range of motion. The injured worker had decreased range of motion in flexion and abduction. The injured worker had a positive median compression test on the right wrist, Phalen's test and Tinel's test. The injured worker had a positive Durkan's on the right wrist. The injured worker underwent x-rays of the shoulder, right wrist and knee. The injured worker underwent an MRI of the right shoulder, nuclear scan of the left knee. The diagnoses included rotator cuff rupture, joint pain shoulder, and joint pain in legs as well as joint pain in the forearm and carpal tunnel syndrome. The treatment plan included Vicodin 5/300 mg 1 every 4 to 6 hours as needed for pain. The injured worker had utilized the Vicodin since at least 11/2014. There was request for authorization submitted for review dated 12/04/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vicodin 5/300mg #10: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement and object decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker had utilized the medication previously. There was a lack of documentation of objective functional improvement, an objective decrease in pain and documentation the injured worker was being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Vicodin 5/300 mg #10 is not medically necessary.