

Case Number:	CM14-0127653		
Date Assigned:	08/15/2014	Date of Injury:	10/20/2003
Decision Date:	09/30/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/12/2014

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 Physical Medicine and Rehabilitation, and Pain Medicine, and is licensed to practice in Texas. 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:

The injured worker is a 60 year old male injured on 10/20/03 due to slip and fall. Diagnoses included sprain of shoulder. Clinical note dated 05/23/14 indicated the injured patient presented complaining of pain with overhead motion, increased neck pain, and numbness going down the arm. Physical examination of the right shoulder revealed active forward elevation significantly less than passive, full passive range of motion, breakaway weakness on testing, tenderness over bicipital groove, tenderness subacromial space, and tenderness over proximal humerus. MRI revealed torn labrum and partial tear of rotator cuff. Medications included Norco, Carisoprodol, Lyrica, clonazepam, Lipitor, Azor. Additionally, requested Botox for management of cervical dystonia, increased Norco to every six hours for night time pain relief and continued Lyrica and Soma for pain/spasms. Prior utilization review approved trigger point injections to the right thoracic spine and left lower thoracic between C4 to C7. The initial request for Hydrocodone, Carisoprodol, diagnostic ultrasound guidance quantity two, and ultrasound extremity nonvascular quantity two was noncertified on 07/25/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 7.5/325mg Quantity: 240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): page(s) 77.

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Specific examples of improved functionality should be provided to include individual activities of daily living, community activities, and exercise able to perform as a result of medication use. As such, Hydrocodone 7.5/325 milligrams quantity 240 cannot be recommended as medically necessary at this time.

Carisoprodol 350mg Quantity: 180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Carisoprodol, Page(s): page(s) 65.

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, Soma is not recommended for long term use. This medication is Food and Drug Administration (FDA) approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy. The documentation indicates that the injured patient is being prescribed the medication for chronic pain and long term care exceeding the recommended treatment window. As such, the request for Carisoprodol 350 milligrams quantity 180 cannot be recommended as medically necessary.

Diagnostic Ultrasound Guidance Quantity: 2.00: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Back, Trigger Point Injections.

Decision rationale: Documentation indicates the use of ultrasound during trigger point injection is not recommended nor supported by current evidence. Additionally, there is discussion in the documentation regarding the requested procedure to substantiate the medical necessity. As such, the request for diagnostic ultrasound guidance quantity two is not recommended as medically necessary.

Ultrasound, extremity, nonvascular Quantity: 2.00: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Back, Trigger Point Injections.

Decision rationale: Documentation indicates the use of ultrasound during trigger point injection is not recommended nor supported by current evidence. Additionally, there is discussion in the documentation regarding the requested procedure to substantiate the medical necessity. As such, the request for ultrasound, extremity, nonvascular quantity two is not recommended as medically necessary.