

Case Number:	CM14-0001816		
Date Assigned:	01/22/2014	Date of Injury:	05/29/2012
Decision Date:	09/24/2014	UR Denial Date:	12/23/2013
Priority:	Standard	Application Received:	01/06/2014

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 Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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 50-year-old male who reported an injury on 05/29/2012 due to a fall. The injured worker's diagnosis was left and right shoulder impingement syndrome, left shoulder sprain, right and left elbow sprain and strain, left lateral epicondylitis, left carpal tunnel syndrome, right carpal tunnel syndrome, right wrist sprain/strain, left wrist sprain/strain, and sleep disturbances. Past treatments include acupuncture and medication therapy. Prior diagnostics included an MRI of the left shoulder, x-ray of the left wrist, x-ray of the left shoulder, and MRI of the wrist. Surgical history includes an open repair of a right inguinal hernia. The injured worker complained of severe, sharp, stabbing, burning, to the right and left shoulder, right and left elbow, and right and left wrist. On physical examination dated 01/10/2014, there was tenderness to palpation of the lateral shoulder, there was muscle spasms of the lateral shoulder, no bruising or swelling to the right shoulder or lesions and there was pain to left and right shoulder, left and right elbow, left and right wrist. Range of motion in all areas mentioned were decreased due to pain. The injured worker's medications were Norco 10/325, Valium 10 mg, and Naprosyn 550 mg. The treatment plan was for continued use of medication as prescribed and the request for Norco 10/325 mg #120. The rationale for the request was not provided with review. The authorization for request form dated 12/02/2013 was submitted for documentation for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325 MG (#120): Upheld

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

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

Decision rationale: The requested Norco 10/325 mg #120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends that opioids used in the management of chronic pain be supported by documented functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 05/2013. However, the most recent clinical evaluation did not provide an adequate assessment of pain relief to include a quantitative assessment of pain or specific functional benefit. Therefore, continued use would not be supported. Furthermore, there is no indication that the injured worker is engaged in an opioid pain management contract or is monitored for aberrant behavior. Therefore, ongoing use of this medication would not be supported in this clinical situation. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such the requested Norco 10/325 mg #120 is not medically necessary or appropriate.