

Case Number:	CM14-0027997		
Date Assigned:	03/19/2014	Date of Injury:	08/17/2007
Decision Date:	09/30/2014	UR Denial Date:	02/17/2014
Priority:	Standard	Application Received:	03/05/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 67 year old male injured on 08/17/04 due to undisclosed mechanism of injury. Current diagnoses included traumatic arthritis of the left wrist; CRPS left upper extremity, and chronic pain syndrome. Clinical note dated 01/24/14 indicated the injured worker presented complaining of left wrist pain and hand pain. Significant portion of the clinical documentation discussed the inability of the injured worker to obtain pain medication. The injured worker reported pain medications allowed him to remain functional, maintain his household, and go out into the community. Pain was exacerbated by activities that involve the hand and improved with rest. The injured worker reported utilizing alcohol and medical marijuana. Physical examination revealed mild edema throughout the left hand and wrist, positive allodynia over the left medial wrist, and active left wrist flexion and extension limited by pain to 20 and 30 degrees respectively. Medications included Norco 10-325mg Q four hours. The initial request for and Norco 10-325mg #150 was non-certified on 02/17/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 PRESCRIPTION FOR NORCO 10/325MG #150: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
CRITERIA FOR USE OF OPIOIDS 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 sufficient documentation regarding the functional benefits and functional improvement obtained with the continued use of narcotic medications. The request for Norco 10/325MG #150 is medically necessary.