

Case Number:	CM14-0048358		
Date Assigned:	06/20/2014	Date of Injury:	06/19/2011
Decision Date:	08/18/2014	UR Denial Date:	03/11/2014
Priority:	Standard	Application Received:	03/19/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 53-year-old female who reported an injury on 06/19/2011, the mechanism of injury provided for review. The injured worker reportedly sustained injuries to multiple body parts and ultimately developed chronic pain. The injured worker's chronic pain was managed with medications. The injured worker was evaluated on 02/04/2014. It was documented that the injured worker's medication schedule included Norco 10/325 mg, up to 8 per day, Ibuprofen 800 mg, twice a day, Amitriptyline 200 mg, every night, gabapentin 800 mg, 3 times a day and Senokot S, 3 times a day. Physical findings included reduced range of motion of the shoulder secondary to pain and increased sensation to touch and palpation of the right wrist, hand and upper extremity. It was noted that there was erythematous mild discoloration of the right hand, wrist and forearm. The injured worker's diagnoses included; left knee pain, mid back pain, right shoulder and upper extremity pain with subsequent reflex sympathetic dystrophy, neck pain, chronic right shoulder pain. It was noted that medications were helpful with pain control. A request was made for a refill of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Hydrocodone/APAP 10/325mg eight tabs a day #480 dispensed 02/04/14:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: The retrospective Hydrocodone/APAP 10/325 mg, 8 tabs a day, #480 dispensed on 02/04/2014 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule Guidelines recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, evidence of pain relief, manage side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence of a quantitative assessment of pain relief or functional benefit related to medication usage. Additionally, there is no documentation that the injured worker is monitored for aberrant behavior. Therefore, continued use of this medication would not be supported on the date of service 02/04/2014. As such, the retrospective request for Hydrocodone/APAP 10/325 mg, 8 tabs a day, #480 dispensed on 02/04/2014 is not medically necessary or appropriate.