

Case Number:	CM15-0009493		
Date Assigned:	01/27/2015	Date of Injury:	12/30/2010
Decision Date:	04/03/2015	UR Denial Date:	01/08/2015
Priority:	Standard	Application Received:	01/16/2015

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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 44-year-old male who reported an injury on 12/30/2010 after an ice machine fell on his arm. The injured worker's treatment history included surgical intervention, postoperative physical therapy, medications, and chiropractic care. The injured worker was evaluated on 12/16/2014. It was documented that the injured worker had right shoulder, right elbow, and right hand pain. The injured worker's diagnoses included status post right carpal tunnel release, status post right elbow, extensor release, and right shoulder impingement. Objective findings included decreased grip strength of the right hand when compared to the left. The injured worker's medications were noted to be Anaprox 550 mg, Fexmid 7.5 mg, tramadol 150 mg, and Protonix 20 mg. The injured worker's treatment plan included a refill of medications. A Request for Authorization form was submitted on 12/29/2014 that included a request for hydrocodone 10/325 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 10/325 mg #60: 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 hydrocodone 10/325 mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends ongoing opioid usage be supported by documented functional benefit, evidence of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation does indicate that the injured worker has a history of taking this medication. The clinical documentation does not provide an adequate assessment of pain relief, functional benefit, or that the injured worker is monitored for aberrant behavior to support continued use of this medication. Furthermore, the request as it is submitted does not identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested hydrocodone 10/325 mg #60 is not medically necessary or appropriate.