

Case Number:	CM15-0189595		
Date Assigned:	10/01/2015	Date of Injury:	07/24/2015
Decision Date:	11/16/2015	UR Denial Date:	09/09/2015
Priority:	Standard	Application Received:	09/25/2015

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

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 33 year old male, who sustained an industrial injury on 07-24-2015. The injured worker was diagnosed as post-operative open reduction and internal fixation of distal radius fracture, and open reduction and internal fixation of scaphoid fracture on 07-29-2015. On medical records dated 08-03-2015, the subjective complaints were noted a post-operative pain was noted to be controlled with medication. Objective findings were noted as right volar wrist and dorsal radial wrist after removal of dressing was appeared clean, dry and healing with no signs of infections. Distal circulation was evaluated and found to be normal. Treatment to date included medication. Current medications were listed as Ibuprofen 600mg. The Utilization Review (UR) was dated 09-09-2015. A Request for Authorization was dated 08-03-2015. The UR submitted for this medical review indicated that the request for Hydroco-APAP 10-325mg #90 and Ibuprofen 800mg #90 was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydroco/APAP 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: The patient presents with right upper extremity pain. The patient is status post right radius and wrist surgery from 07/29/2015 (39B). The current request is for Hydrocodone/APAP 10/325mg #90. The treating physician's report dated 08/10/2015 (38B) states, "He states that he is taking his Norco 1 tablet every 4 hours instead of every 6 hours with Ibuprofen three times a day." Reports show that the patient was prescribed Norco prior to 08/03/2015. For chronic opiate use, the MTUS guidelines page 88 and 89 on criteria for use of opioids states, "pain should be assessed at each visit, and functioning should be measured at six-month intervals using a numerical scale or validated instrument." MTUS page 78 On-Going Management also require documentation of the 4A's including analgesia, ADLs, adverse side effects, and aberrant drug seeking behavior, as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medications to work, and duration of pain relief. None of the reports provided before and after pain scales to show analgesia. The physician does not provide specific examples of ADLs to demonstrate medication efficacy. No validated instruments were used. There are no pain management issues discussed such as CURES report, pain contract, etc. No outcome measures were provided as required by MTUS Guidelines. The physician did not provide a urine drug screen to see if the patient is compliant with his prescribed medications. In this case, the physician has not provided the proper documentation of the required criteria based on the MTUS Guidelines for continued opiate use. The current request is not medically necessary.

Ibuprofen 800mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The patient presents with right upper extremity pain. The patient is status post right radius and wrist surgery from 07/29/2015 (39B). The current request is for Ibuprofen 800mg #90. The treating physician's report dated 08/10/2015 (38B) states, "He states that he is taking his Norco 1 tablet every 4 hours instead of every 6 hours with Ibuprofen three times a day." The 08/03/2015 report notes medication efficacy stating, "The post-operative pain is adequately controlled with prescribed analgesic." The MTUS Guidelines page 22 on anti-inflammatory medication states that anti-inflammatories are the traditional first-line treatment to reduce pain so activity and functional restoration can resume, but long term use may not be warranted. MTUS page 60 on medications for chronic pain states that pain assessment and functional changes must also be noted when medications are used for chronic pain. Medical records show that the patient was prescribed Ibuprofen prior to 08/03/2015. In this case, the physician has noted medication efficacy and continued use is appropriate. The current request is medically necessary.