

Case Number:	CM15-0024338		
Date Assigned:	02/13/2015	Date of Injury:	10/10/2013
Decision Date:	04/14/2015	UR Denial Date:	02/03/2015
Priority:	Standard	Application Received:	02/09/2015

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 25-year-old male who reported an injury on 10/10/2013. The mechanism of injury was the injured worker felt a pop in his right wrist when he was using a 10 key. The injured worker's prior treatments included physical therapy. Prior testing included an EMG, an MRI and an MRI arthrogram of the right wrist. The documentation of 01/28/2015 revealed the injured worker had complaints of neck and right upper extremity pain. The physical examination revealed tenderness over the TFCC and ulnar styloid with crepitus. There was decreased sensation and 8 mm 2-point discrimination in the ulnar palm. The injured worker had a positive Hawkins and had subacromial tenderness in the right shoulder. The documentation indicated the MR arthrogram revealed a ganglion cyst. The diagnosis included rule out cervical radiculopathy, rule out right shoulder impingement syndrome, rule out double crush rule out TFCC tear, and rule out shoulder impingement. Treatment plan included Ultram 150 mg and hydrocodone. There was a Request for Authorization submitted for review dated 01/28/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-going management, Opioids Page(s): 78-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

Decision rationale: The California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Norco 10/325 mg is not medically necessary.

Diazepam 10mg #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Benzodiazepines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The California Medical Treatment Utilization Guidelines do not recommend the use of benzodiazepines for longer than 4 weeks due to the possibility of psychological or physiological dependence. The clinical documentation submitted for review failed to provide the duration of use. The efficacy was not provided. There was a lack of documentation indicating a necessity for 100 tablets. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for diazepam 10 mg #100 is not medically necessary.