

Case Number:	CM15-0028680		
Date Assigned:	02/20/2015	Date of Injury:	10/01/2006
Decision Date:	04/01/2015	UR Denial Date:	01/29/2015
Priority:	Standard	Application Received:	02/17/2015

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: New Jersey, New York
Certification(s)/Specialty: Family Practice

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 47 year old female, who sustained an industrial injury on 10/1/2006. The diagnoses have included right wrist tenosynovitis/De Quervain's Syndrome and right shoulder sprain/strain. Treatment to date has included medication. According to the Primary Treating Physician's Progress Report dated 1/8/2015, the injured worker's symptoms were unchanged and pretty well maintained with medications. Objective findings revealed tenderness at the right elbow. Treatment plan noted the injured worker to be at elevated risk for opiate use but no aberrant behavior. Pain with medications was rated 4-6/10. Pain without medications was rated 8-10/10. Authorization was requested for bilateral wrist braces, a cervical spine pillow, Tylenol #4 and a urine drug screen. On 1/29/2015, Utilization Review (UR) non-certified a request for Tylenol #4 300/30mg one by mouth every six hours as needed #120. The Medical Treatment Utilization Schedule (MTUS) was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tylenol #4 300/30mg 1 po prn #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 92, 78-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 78-79.

Decision rationale: The request for Tylenol #4 is considered medically necessary. The patient has been on opiates with objective documentation of the improvement in pain. There is improvement in specific ADLs and patient is able to function more with the use of Tylenol #4. The patient is on multiple medications which were causing light-headedness for which she was taken off her sleep aid. There is documentation of the four A's of ongoing monitoring: pain relief, side effects, physical and psychosocial functioning, and aberrant drug-related behaviors. The urine drug screen included in the chart was consistent. Because of these reasons, the request is considered medically necessary at this point.