

Case Number:	CM15-0062616		
Date Assigned:	04/08/2015	Date of Injury:	02/14/2014
Decision Date:	05/08/2015	UR Denial Date:	03/19/2015
Priority:	Standard	Application Received:	04/02/2015

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

Certification(s)/Specialty: Emergency Medicine

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 sustained an industrial injury on 2/14/14. She reported initial complaints of right wrist and right elbow pain. The injured worker was diagnosed as having adhesive capsulitis right shoulder; complex regional pain syndrome; posttraumatic radial head fracture; carpal tunnel syndrome. Treatment to date has included status post right elbow radial head repair/titanium arthroplasty (2014); EMG/NCV upper extremities (2014); physical therapy; medications. Currently, the PR-2 notes dated 3/16/15 the injured worker complained of right elbow, hand and shoulder pain. The provider's examination found weakness, restricted range of motion, and operative elbow scar from a status post radial head titanium arthroplasty and allodynia. There is no functional improvement documented and the injured worker indicates pain levels increase with physical therapy. The provider has requested Norco 10/325mg, #120 1 tab every 6 hours PRN.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Therapeutic Trial of Opioids Page(s): 76-78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82 Page(s): 78-82.

Decision rationale: The requested Norco 10/325mg, #120, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has right upper extremity pain. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract or urine drug screening. The criteria noted above not having been met, Norco 10/325mg, #120 is not medically necessary.