

Case Number:	CM13-0051390		
Date Assigned:	12/27/2013	Date of Injury:	06/16/2009
Decision Date:	02/21/2014	UR Denial Date:	09/27/2013
Priority:	Standard	Application Received:	10/07/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management has a subspecialty in Disability Evaluation and is licensed to practice in California, Washington D.C., Florida, and Maryland. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 claimant is a 48 year old with stated date of injury of 06/16/2009. According to the records reviewed, the claimant stated that while carrying two buckets of cement (weighing -20-30 pounds each), he placed the buckets on the ground and as he attempted to retrieve the buckets, he went to lift them though could not straighten up as he had developed the acute onset of lower back pain. The pain was so severe that he had to lie on the floor. He reported the injury to his supervisor and went home. He returned to the emergency room complaining of increased back and left leg pain. Some x-rays were taken at that time, which were unremarkable. He was eventually referred for a lumbar MRI scan and was told that he had an injured disc. An MRI of the lumbar spine dated 02/14/11, revealed significant degenerative disc changes at the L5-S1 level with disc osteophyte complex formation combined with facet joint hypertrophy causing marked bilateral neuroforaminal narrowing and significant bilateral lateral recess narrowing. Prominent disc osteophyte complex formation was also found at the L4- L5 level combined with facet joint hypertrophy causing moderate to marked bilateral neuroforaminal narrowing and significant bilateral lateral recess narrowing. Disc bulging at the L3-4 level combined with facet joint hypertrophy causing mild to moderate, right greater than left, neuroforaminal narrowing. An electromyogram/nerve conduction study (EMG/NCS) dated 02/18/11 revealed a normal EMG with no evidence of radiculopathy. A supplemental report dated 10/03/13, identifies a review of records, which noted that it was unclear whether the patient was ever offered epidural steroid injections (ESI) or whether he simply did not want to pursue this line of treatment. It was agreed that at least one epidural steroid injection would be reasonable. Authorization was requested for pain management evaluation and one ESI. The most recent PR-2 note, dated 09/17/13, reveals the patient presented reporting

IMR ISSUES, DECISIONS AND RATIONALES

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

Vicodin 5/325mg (#60) x 3 Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 52, 76, 77 and 93.

Decision rationale: CA-MTUS (July 18, 2009) page 76 through 77 of 127, section on Opioids states: Vicodin® is a short-acting opioid. Short acting opioids, also known as "normal-release" or "immediate-release" opioids, are seen as an effective method in controlling chronic pain. They are indicated for moderate to moderately severe pain, and are often used for intermittent or breakthrough pain. These agents are often combined with other analgesics such as acetaminophen and aspirin. These adjunct agents may limit the upper range of dosing of short acting agents due to their adverse effects. The MTUS guidelines recommended that ongoing use of Opioids is indicated (a) If the patient has returned to work, or (b) If the patient has improved functioning and pain. The patient has been on Vicodin since October of 2012, and medical reports do not identify measurable analgesic benefit (Visual Analog Scores) with the use of opioids, and there is no documentation of functional/vocational benefit with ongoing use. The physical examination findings were minimal. There is no documentation of a urine drug screen (UDS) performed to monitor compliance and screen for aberrant behavior, and no documentation of a signed opiate agreement. Ongoing use of chronic opioids is not supported in the current clinical setting. Therefore the prescription of Vicodin is not medically necessary