MAXIMUS Federal Services

Case Number:	CM14-0003663		
Date Assigned:	01/17/2014	Date of Injury:	12/20/2005
Decision Date:	06/09/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	01/08/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Texas and Oklahoma. 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/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 injured worker is a 57 year old male who reported an injury on 12/20/2005. The mechanism of injury was a slip and fall. The clinical note dated 10/21/2013 reported the injured worker noted he was doing better. The injured worker complained of low back pain, associated with shooting pain down into left leg and pain to the left knee. The injured worker continued to struggle with long distance walking and had been using an electrical wheelchair. The injured worker noted the pain was unchanged and described as a sharp, stabbing and miserable in nature. The injured worker rated pain at 8/10. The injured worker also reported left ankle pain and swelling. They physical exam noted there was no atrophy or deformity to the upper and lower extremities, no swelling in the bilateral lower extremities. The left knee was tender to palpation. The range of motion was unable to be determined due to the severity of the injured workers pain. The injured worker had diagnoses of chronic low back pain, left knee pain s/p arthroscopy surgery. The provider requested a refill of Hydrocodone 10/325 MG, # 240. The request for authorization was not provided in the clinical documentation submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

HYDROCODONE 10/325MG #240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

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

Decision rationale: The injured worker noted he was doing better. The injured worker complained of low back pain, associated with shooting pain down into the left leg and pain to the left knee. The injured worker continued to struggle with long distance walking and had been using an electrical wheelchair. The injured worker noted the pain was unchanged and described as a sharp, stabbing and miserable in nature. The injured worker rated pain at 8/10. The injured worker also reported left ankle pain and swelling. The California MTUS guidelines recommend on-going review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines also note the use of a drug screening or inpatient treatment with issues of abuse, addiction or poor pain control. There was a lack of objective functional improvement and pain relief indicating the efficacy of the hydrocodone. In addition there was a lack of an updated urine drug screen in the clinical documentation provided. Therefore the request for Hydrocodone 10/325 mg, # 240 is not medically necessary.