

Case Number:	CM14-0108118		
Date Assigned:	08/01/2014	Date of Injury:	06/20/2011
Decision Date:	09/09/2014	UR Denial Date:	07/11/2014
Priority:	Standard	Application Received:	07/11/2014

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 Ohio. 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 52-year-old male who reported an injury on 06/20/2011. The mechanism of injury was not stated. Current diagnoses include left greater trochanteric bursitis, status post L5-S1 microdiscectomy with interbody fusion on 01/15/2014, stitch abscess, lumbar wound dehiscence, recurrent disc herniation at L5-S1, status post L5-S1 microdiscectomy on 10/04/2011, status post right cubital tunnel release on 01/08/2013, and malpositioned right L5 screw. The injured worker was evaluated on 06/09/2014, with complaints of persistent lower back pain with numbness in the bilateral lower extremities. The current medication regimen includes Norco, Soma, Bactrim DS, Restoril, Dilaudid, Neurontin, and Lyrica. Physical examination revealed tenderness to palpation, a well-healed ulnar release scar, limited lumbar range of motion, an antalgic gait, decreased sensation over the right L3 and L5 dermatome, and positive straight leg raising bilaterally. Treatment recommendations included prescriptions for Zohydro ER and Lyrica 50 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zohydro ER strength: 30mg Quantity: 60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid therapy for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82..

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the injured worker does currently utilize Norco and Dilaudid. The medical necessity for adding an additional opioid medication has not been established. There was also no frequency listed in the request. As such, the request is non-certified.