

Case Number:	CM14-0012196		
Date Assigned:	02/21/2014	Date of Injury:	10/02/2001
Decision Date:	08/13/2014	UR Denial Date:	01/14/2014
Priority:	Standard	Application Received:	01/30/2014

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 California and Washington. 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 45-year-old male with a reported injury on 10/02/2001. The mechanism of injury was not provided. The injured worker did have an examination on 03/12/2014 for a followup of low back pain that had increased more recently. He rated the back pain at a 6/10 on the pain scale. He reported that sitting for an extended period of time did worsen his pain. His list of medications included hydrocodone/APAP and Omeprazole. His diagnosis consisted of status post lumbar fusion which is stable. No functional deficits were provided and there was no evidence of any previous treatment such as physical therapy, home exercise programs, or NSAIDs that had been attempted. The recommended plan of treatment was to continue his medications. The request for authorization was signed and dated 03/12/2014. The rationale was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 PRESCRIPTION OF HYDROCODONE/APAP 10/325MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 78-80.

Decision rationale: The request for 1 prescription of Hydrocodone/APAP 10/325MG #90 is not medically necessary. The injured worker has been prescribed the hydrocodone since 05/17/2013. He has attempted a home exercise program with stretching and has had previous treatment of hot packs. The efficacy of the medications and/or the exercise program was not provided. California MTUS Guidelines recommend for ongoing monitoring documentation to include pain relief, side effects, physical and psychological functioning, and the occurrence of any potentially aberrant or nonadherent drug related behaviors. Again, the effectiveness of his medications was not provided. There were no physical or psychosocial functioning deficits provided. The injured worker did have a urinalysis done on 10/23/2013 which was consistent with the hydrocodone although the urinalysis did show the use of marijuana. Also, they should discontinue if there is no overall improvement in function unless there are extenuating circumstances. Again, there was no functional improvement provided or efficacy of the medication. Furthermore, the request does not specify directions as far as frequency. Therefore, the request for prescription of Hydrocodone/APAP 1 prescription of Hydrocodone/APAP 10/325MG #90 is not medically necessary.