MAXIMUS Federal Services

Case Number:	CM14-0118201		
Date Assigned:	08/06/2014	Date of Injury:	08/28/2004
Decision Date:	09/16/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/28/2014

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, has a subspecialty in Pain Medicine 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 52-year-old male, who reported an injury on 08/28/2004. The mechanism of injury was not provided for clinical review. The diagnoses include lumbar disc displacement without myelopathy, chronic pain syndrome, depression. The medication regimen included gabapentin, carisoprodol, hydrocodone/acetaminophen, and morphine sulfate. The previous treatments included medication. Within the clinical note dated 06/24/2014, it was reported the injured worker complained of persistent severe back pain. He complained of bilateral knee pain and bilateral hip pain. Upon the physical examination, the provider noted the injured worker to have decreased sensation in the left/right S1 dermatome. The injured worker had a positive straight leg raise on the right. The provider noted the injured worker had spasms and guarding of the lumbar spine. The request submitted is for hydrocodone. However, a rationale is not provided for clinical review. The Request for Authorization was not provided for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/Acetaminophen 10/325 qty #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80.

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

Decision rationale: The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen and inpatient treatment with issues of abuse, addiction, or poor pain control. The provider did not document an adequate and complete pain assessment within the documentation. There is lack of documentation indicating the medication had been providing objective functional benefit and improvement. Additionally, the use of a urine drug screen was not provided for clinical review. The request submitted failed to provide the frequency of the medication. Therefore, the request Hydrocodone/Acetaminophen 10/325 quantity #120 is not medically necessary.