

<b>Case Number:</b>	CM14-0140346		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	10/02/2004
<b>Decision Date:</b>	11/05/2014	<b>UR Denial Date:</b>	08/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/29/2014

### 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 Family Medicine and is licensed to practice in California. 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:

This 51 year old patient had a date of injury on 10/2/2004. The mechanism of injury was the truck was bouncing up and down, causing a back injury. In a progress noted dated 7/2/2014, the patient complains of ongoing lower back pain that extends to both legs down to the feet. His muscles wont relax, and he has severe problem with insomnia and is constantly sleepy and fatigued. On a physical exam dated 7/2/2014, there was depression, anxiety, insomnia and fatigue. There was tenderness to lumbar spine, with decreased flexion, decreased extension and decreased lateral bending. The diagnostic impression shows lumbago, radiculitis of lumbar and thoracic area, myofascial pain syndrome. The treatment to date includes medication therapy, and behavioral modification. A UR decision dated 8/5/2014 denied the request for Tylenol #3 #90x1, stating that the documentation does not show ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tylenol-Codeine #3, 30 mg, QTY: 90 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

**Decision rationale:** The CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, in the 7/2/2014 progress report, there was no documented functional improvement noted from the opioid regimen, and this patient has been on Tylenol #3 since at least 5/8/2014. Furthermore, there was no discussion regarding adverse side effects and tolerability of this medication. Therefore, the request for Tylenol #3#90x1 refill was not medically necessary.