

Case Number:	CM14-0029247		
Date Assigned:	06/20/2014	Date of Injury:	02/28/1997
Decision Date:	07/17/2014	UR Denial Date:	02/27/2014
Priority:	Standard	Application Received:	03/07/2014

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. 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 66-year-old with a reported injury on February 28, 1997. The mechanism of injury was not provided. The injured worker had an exam on January 14, 2014 with complaints of low back pain radiating to hips and buttocks, right leg and heel. The last procedure in July of 2013 had positive pain relief following radiofrequency. Radiofrequency, medications, and injections kept the pain manageable and she walked daily for exercise. Her diagnoses were right lumbar facet pain, left lumbar facet pain, stable, and bilateral sacroiliac joint pain. Her medication list consisted of Hydrocodone-acetaminophen, Tizanidine, and Tramadol. There was lack of documentation of pain assessments and evaluation of effectiveness. There was no evidence of conservative treatment such as heat/ice, physical therapy, or home exercise program. There was not a urinalysis provided. The request for authorization was signed January 22, 2014. The rationale for the request was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

HYDROCODONE/ACETAMINOPHEN 10/325MG, 270 COUNT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram), Hydrocodone, Opioids, criteria for use, Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 74-78.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend four domains relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug related behaviors. There was a lack of documentation on any pain assessment or evaluation, nor was there any documentation on a psychosocial evaluation provided. There was not a urinalysis provided. Furthermore, the request did not specify directions and duration of the medication. The guidelines also recommend the lowest dose possible and there is no evidence of weaning or tapering the medication. The request for Hydrocodone/Acetaminophen 10/325mg, 270 count, is not medically necessary or appropriate.