

Case Number:	CM14-0031189		
Date Assigned:	06/20/2014	Date of Injury:	02/06/2003
Decision Date:	07/17/2014	UR Denial Date:	02/06/2014
Priority:	Standard	Application Received:	03/10/2014

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 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 59-year-old male who reported an injury on 02/06/2003. The mechanism of injury was not provided within the medical records. The clinical note dated 05/09/2014 indicated lumbar disc displacement, lumbar radiculopathy, lumbar spinal stenosis, bilateral knee pain, anxiety, constipation, gastritis, gastroesophageal reflux disorder, medication-related dyspepsia, vitamin D deficiency, chronic pain, and constipation unspecified. The injured worker reported low back pain that radiated down the bilateral lower extremities that was aggravated by activities and walking. He rated his pain 6/10 with medication and 10/10 without medication. The injured worker reported activity of daily living was limited in the following areas: self-care, hygiene, activity, ambulation, sleep, and sex. The injured worker reported the use of opioid pain medication was helpful. He reported the time until pain relief was approximately 1 1/2 hour. He reported the least reported pain since last assessment was 5 on a scale of 1 to 10. The injured worker reported areas of functional improvement included ability to attend church and activities of daily living. The injured worker reported his quality of life had improved as a result of opioid pain medication and he wished to continue therapy based on his decreased pain, his increased level of function, had improved his quality of life. On physical examination of the cervical and lumbar spine, range of motion was limited secondary to pain. The injured worker's prior treatments included diagnostic imaging and medication management. The injured worker's medication regimen included Carisoprodol, Soma, Clorazepate, Gabapentin, Hydrocodone/APAP, Naproxen, Pantoprazole, Vitamin D and Zolpidem. The provider submitted a request for Hydrocodone. A Request for Authorization was not submitted for review to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 10-325 #90 for the purpose of weaning to below 120 MED of all opioids with a reduction of Meds by 10%-20% per week over a weaning period of 2-3 months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 2014 Pain Chapter: Long-Term Assessment - Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, On-going Management Page(s): 78.

Decision rationale: The request for for Hydrocodone 10/325 #90 for the purpose of weaning to below 120 MED of all opioids with a reduction of Meds by 10%-20% per week over a weaning period of 2 to 3 months is non-certified. The California MTUS Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. Although the injured worker has reported pain relief and functional improvement from the medication the provider did not indicate a frequency for the medication. Therefore, the request for Hydrocodone 10/325 not medically necessary.