MAXIMUS Federal Services

Case Number:	CM14-0039285		
Date Assigned:	06/27/2014	Date of Injury:	12/31/1996
Decision Date:	09/17/2014	UR Denial Date:	03/24/2014
Priority:	Standard	Application Received:	04/03/2014

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 & Rehabilitation has a subspecialty in Pain Medicine and is licensed to practice in Texas & Ohio. 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 56-year-old male who reported an injury on 12/31/1996 due to a fall. The injured worker's past diagnostics include heart catheterization. Past surgeries include two left knee surgeries in 1998 and 2006 and a right knee replacement in 1997. Prior treatments include medication and occasional use of a cane. The injured worker complained of low back pain, bilateral lower extremity tingling and numbness, as well as bilateral knee pain. The injured worker complained that the pain was worse in the knees and was having some difficulty with his activities due to the back and leg complaints. On physical examination dated 07/18/2013, the injured worker complained of bilateral knee pain that was rated 4-5/10 and indicated his pain level fluctuated depending on the day. He reported that his medications were allowing him to control his pain and allow him to function. He denied any side effects of the medications. Examination revealed the injured worker had an antalgic gait, tenderness to palpation of the lumbar paraspinals with spasm noted in the bilateral paraspinal. Range of motion of the lumbar spine was decreased due to pain. Examination of the bilateral knees revealed patellofemoral crepitus and decreased range of motion. It was noted the 04/29/2013 CURES report was consistent and a urine drug screen performed on 01/14/2013 was negative for all substances which was reported as inconsistent. A urine drug screen performed on 10/31/2013 revealed the sample was negative for the prescribed hydrocodone and Norco and was consistent with Xanax. The injured worker's medications included Norco 10/325, Xanax 0.5 mg, Celebrex 100 mg and Senna as needed. The rationale for the request was not submitted with documentation. The Request for Authorization was dated 07/18/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

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

Decision rationale: The California MTUS Guidelines recommend the documentation of pain relief functional status, appropriate medication use, and side effects. The guidelines also recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction or poor pain control. The injured worker has been utilizing the medication since at least 04/2012. The provider failed to document a complete and adequate pain assessment. The injured worker rated his pain 4-5/10; however, there was a lack of information as to the pain score before and after medication. The injured worker denied side effects; however, the urine drug screen reports provided revealed inconsistent results which would not support continuation of the medication. There was a lack of objective functional improvement documented as a result of the medication to support continuation. The request as submitted failed to provide the frequency of the medication. As such, the request for Hydrocodone 10/325mg #120 is not medically necessary.