

Case Number:	CM14-0055877		
Date Assigned:	07/09/2014	Date of Injury:	09/07/2012
Decision Date:	08/29/2014	UR Denial Date:	03/27/2014
Priority:	Standard	Application Received:	04/25/2014

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 Orthopedic Surgery and is licensed to practice in Arizona. 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 46-year-old female sustained an injury on 9/7/2012. The specifics of the injury are not available. A progress note of 3/18/2014 states the patient's pain remains 9/10. She has completed physical therapy and is now doing a home exercise program. She would like to try more acupuncture. The pain remains in the low back and in the right buttocks. Medication helps and she needs a refill. She has not returned to work. Objective findings include normal reflex, normal sensory and motor function, a negative straight leg raise and a normal gait. She has mild lumbar tenderness and limitation of motion of the lumbar spine. MRI of the lumbar spine on 3/22/2013 reveals scoliosis with mild disc bulging at multiple levels. A request is made to continue the use of Hydrocodone/APAP 10/325 and tramadol 150 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: The criteria for ongoing management with opioids are well defined in the chronic pain guidelines. There needs to be documentation of ongoing monitoring such as level of pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behavior. The patient should be requested to keep a pain diary. This should be documentation of misuse of medication and as consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. This patient states her pain is 9/10 and yet she has no objective physical findings. Even the subjective findings of tenderness to palpation are considered mild. Her pain level is described as 9/10 despite the opioids she is taking. There is no documentation of her physical or psychosocial functioning. There is no documentation of the occurrence of any potentially aberrant drug-related behaviors. She is apparently getting drug screening although the results are not available. She is showing no functional improvement on opioid therapy. Therefore, the request is not medically necessary and appropriate.

Tramadol HCL 150mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: The criteria for ongoing management with opioids are well defined in the chronic pain guidelines. There needs to be documentation of ongoing monitoring such as pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behavior. The patient should be requested to keep a pain diary. This should be documentation of misuse of medication and consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. This patient states her pain is 9/10 and yet she has no objective physical findings. Even the subjective findings of tenderness to palpation are considered mild. Her pain level is described as 9/10 despite the opioids she is already taking. There is no documentation of her physical or psychosocial functioning. There is no documentation of the occurrence of any potentially aberrant drug-related behaviors. She is apparently getting drug screening although the results are not available. She is showing no functional improvement on opioid therapy. Therefore, the request is not medically necessary and appropriate.