

Case Number:	CM14-0065817		
Date Assigned:	07/11/2014	Date of Injury:	12/30/2004
Decision Date:	09/03/2014	UR Denial Date:	05/01/2014
Priority:	Standard	Application Received:	05/08/2014

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 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:

The injured worker is a 48-year-old female who reported an injury on 12/30/2004. The mechanism of injury was not provided for the clinical review. The diagnoses included lumbar radiculopathy, status post lumbar spine fusion and fibromyalgia. Previous treatments included surgery and medication. Previous diagnostic imaging included MRI. Within the clinical noted dated 05/08/2014, the injured worker complained of neck pain which radiated down the right upper extremity. She complained of low back pain which radiated down the bilateral lower extremities. The injured worker complained of upper extremity pain in the left arm, elbow, hand, shoulder and wrist. She rated her pain 10/10 without medications. Upon the physical examination of the lumbar spine, the provider noted the injured worker to have spasms. The provider indicated there was tenderness to palpation in the spinal vertebral area at L4-S1 levels. The range of motion of the lumbar spine was moderately limited secondary to pain. The provider indicated the injured worker had tenderness of the upper extremities. The range of motion was within normal limits. The provider requested for hydrocodone bitartrate and acetaminophen 10/325 mg. However, rationale is not provided for clinical review. The provider requested for bitartrate and acetaminophen for pain, the Request for Authorization was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone Bitartrate & Acetaminophen 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 58, 80-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Page(s): 78..

Decision rationale: The request for hydrocodone bitartrate and acetaminophen 10/325 #120 is non-certified. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction or poor pain control. The provider failed to document a complete and adequate pain assessment. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The injured worker has been utilizing the medication since 12/2013. Additionally, the use of a urine drug screen was not provided for clinical review. Therefore, this request is not medically necessary.