

Case Number:	CM14-0099421		
Date Assigned:	07/28/2014	Date of Injury:	07/28/2005
Decision Date:	08/29/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	06/27/2014

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 and is licensed to practice in California and Washington. 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 44-year-old male who reported an injury on 07/28/2005. The mechanism of injury was not submitted in the report. The injured worker has diagnoses of lumbar radiculopathy, chronic low back pain, grade one spondylolisthesis at L4-5 and lumbar HNPS with neural foraminal narrowing. The injured worker's past treatment includes physical therapy, chiropractic treatment, epidural injections, a home exercise program, and medication therapy. The injured worker underwent an MRI on 07/17/2014 that revealed mild degenerative disc disease without levels of spinal stenosis and mild left neural foraminal narrowing at L3-4 and mild left greater than right neural foraminal narrowing results at L4-5. The injured worker complained of low back pain and lower extremity pain. He rated his back and leg pain at a 3-8/10 on the pain scale. He also stated that he had an increased burning pain in his left calf. The physical examination dated 07/29/2014 revealed that the injured worker's range of motion of the lumbar spine was decreased in all planes. He had decreased sensation in the L4 dermatome on the left. Psoas, hamstrings, and quads were 4+/5 bilaterally. The tibialis anterior, EHL, inversion, and eversion were 4+/5 on the left. The tibialis anterior, EHL, inversion, and eversion were 5-/5 on the right. Straight leg raise was bilaterally at 30 degrees caused radiation of pain down the posterior thighs. The injured worker's medications include Norco 10/325 mg, Prilosec 20 mg, Flexeril for severe spasms, and naproxen 550 mg. The injured worker stated that the medication helped decrease his pain by more than 50%. The treatment plan discussed with the injured worker consisted of an option of micro lumbar decompressive surgery due to recent flare ups of his back pain over the past few weeks, which he attributes to prolonged sitting while traveling on vacation and during work activities. Also to include the continuation of medication, this includes hydrocodone/APAP 10/325 mg. The rationale and Request for Authorization form were not submitted for review.

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.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen, Ongoing Management Page(s): 91, 78.

Decision rationale: The injured worker complained of low back pain and lower extremity pain. He rated his back and leg pain at a 3-8/10 on the pain scale. He also stated that he had an increased burning pain in his left calf. The California MTUS guidelines recommend hydrocodone/acetaminophen for moderate to moderately severe pain and it indicates that for ongoing management. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be submitted. Pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. As per guidelines above, the documentation submitted lacked evidence of the 4 A's being adequately addressed. Given the above, the injured worker was not within MTUS Guidelines. There was no documentation regarding the measurement of pain of the injured worker with and without the hydrocodone/acetaminophen. There were no side effects listed in the submitted reports. There was no evidence that the hydrocodone/acetaminophen was helping with any functional deficits the injured worker had. The report also lacked a urinalysis or drug screen showing that the injured worker was compliance with the MTUS Guidelines. The request as submitted also failed to provide the frequency of the medication. As such, the request for Hydrocodone/APAP 10/325 MG, #90 is not medically necessary.