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| Case Number: | CM14-0142850 | | |
| Date Assigned: | 09/10/2014 | Date of Injury: | 08/09/2013 |
| Decision Date: | 05/13/2015 | UR Denial Date: | 08/22/2014 |
| Priority: | Standard | Application Received: | 09/03/2014 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 43 year old male with an industrial injury dated August 9, 2013. The injured worker diagnoses include lumbar disc disease, lumbar radiculopathy, lumbar facet syndrome, and right sacroiliac joint arthropathy. He has been treated with diagnostic studies, prescribed medications, transforaminal epidural steroid injection (ESI) on 7/30/2014 and periodic follow up visits. According to the progress note dated 08/01/2014, the injured worker reported lumbar spine pain. Objective findings revealed antalgic gait on the right, diffuse lumbar paraspinal muscle tenderness, moderate facet tenderness at L3-S1, positive sacroiliac tenderness, decreased range of motion of the lumbar spine and decreased sensation in the L3 and L4 dermatomes on the right. The treating physician prescribed Hydrocodone 10/325 mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 10/325 mg #90: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (1) Pain Outcomes and Endpoints, (2) Opioids, criteria for use, (3) Opioids, dosing Page(s): 8, 76-80, 86.

Decision rationale: The claimant sustained a work injury in August 2013 and continues to be treated with low back pain. Medications include hydrocodone being prescribed at a total MED (morphine equivalent dose) of 30 mg per day. The treating provider references Norco as helping with pain and without adverse effect. When seen, there had been a sudden increase in back pain and pain was rated at 10/10. Norco, Flexeril, and Motrin were prescribed. When prescribing controlled substances for pain, satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Hydrocodone / acetaminophen is a short acting combination opioid often used for intermittent or breakthrough pain. In this case, it is being prescribed as part of the claimant's ongoing management with some degree of pain relief. The total MED is less than 120 mg per day consistent with guideline recommendations. Therefore, the continued prescribing of hydrocodone/acetaminophen was medically necessary.