

Case Number:	CM14-0186647		
Date Assigned:	11/14/2014	Date of Injury:	06/19/2010
Decision Date:	01/05/2015	UR Denial Date:	10/22/2014
Priority:	Standard	Application Received:	11/10/2014

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 Preventative (Occupational) Medicine and is licensed to practice in New Hampshire, New York, Massachusetts. 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 52-year-old female who reported injury on 02/19/2010. The mechanism of injury was not submitted for review. The injured worker has a diagnosis of meniscal tear of the right knee, osteoarthropathy of the right knee, multidirectional instability of the right knee, foraminal stenosis at L4-5 and L5-S1, facet osteoarthropathy at L4-5 and L5-S1, left knee pain, fracture right 5th metatarsal, status post gastric bypass, and reactive depression. Past medical treatment consists of surgery, stretching exercises, moist heat, use of a TENS unit, cold packs, and medication therapy. Medications consist of pantoprazole, cyclobenzaprine, NSAID (not specified what NSAID), and hydrocodone/acetaminophen. On 10/13/2014, the injured worker underwent a urine drug screen. Test revealed that the injured worker was compliant with prescription medications. On 07/16/2014, the injured worker complained of low back pain. It was noted that the injured worker rated the pain at a 7/10. Physical findings revealed tenderness of the lumbar spine. Lumbar range of motion was markedly limited. Spasm in the lumbar paraspinal musculature was decreased. Medical treatment plan is for the injured worker to continue with medication therapy. Rationale was not submitted for review. The Request for Authorization form was submitted on 04/16/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone-Acetaminophen 7.5-325mg/15ml Soln #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids,
Page(s): 78.

Decision rationale: There were no assessments submitted for review indicating what pain levels were before, during, and after medication administration. Additionally, there was no evidence submitted for review showing that the hydrocodone/acetaminophen was helping with any functional deficits the injured worker had. A urine drug screen obtained on 10/30/2014 showed that the injured worker was compliant with prescription medications. However, there was no indication as to why the injured worker is unable to use oral tablets versus oral solution. Given the above, the injured worker is not within MTUS recommended guideline criteria. As such, the request is not medically necessary.