

Case Number:	CM14-0186975		
Date Assigned:	11/17/2014	Date of Injury:	09/21/2001
Decision Date:	01/05/2015	UR Denial Date:	10/21/2014
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 General Preventive Medicine and is licensed to practice in Indiana. 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 employee is a 57 year old female with date of injury of 9/21/2001. A review of the medical records indicated that the patient is undergoing treatment for reflex sympathetic dystrophy of the lower limb. Subjective complaints include continued 8/10 pain in her lower back and bilateral lower extremities with numbness and tingling. Objective findings include limited range of motion of the lumbar spine with tenderness to palpation of the paravertebrals. The patient was able to extend left knee with assistance of her arms; weak left extensor hallenius longus noted; right lower extremities 4+/5 strength, no extensor hallicus longus weakness; and hyperalgesia reported throughout lower left extremities. Treatment has included Norco, Ibuprofen and physical therapy. The utilization review dated 10/24/2014 non-certified hydrocodone / acetaminophen 10/325mg tab x 120.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/acetaminophen 10/325mg tab x 120, with 0 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91, 78-80, and 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Neck and Upper Back (Acute and Chronic), Low Back - Lumbar & Thoracic (Acute & Chronic), Opioids, Pain

Decision rationale: Official Disability Guidelines (ODG) does not recommend the use of opioids for low back pain "except for short use for severe cases, not to exceed 2 weeks." The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. 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. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. As such, this request is not medically necessary.