

Case Number:	CM14-0195993		
Date Assigned:	11/25/2014	Date of Injury:	01/19/2008
Decision Date:	01/20/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	11/13/2014

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 Family Medicine and is licensed to practice in New York and New Jersey. 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 72-year-old male, with a reported date of injury of 01/09/2006 due to cumulative trauma. The current diagnosis includes lumbar sprain/strain. The past diagnoses include bilateral ankle sprain; status post bilateral carpal tunnel release; status post right laminectomy; neck sprain; cervical intervertebral disc displacement without myelopathy; and brachial neuritis or radiculitis. Treatments have included an x-ray of the right knee; Motrin 600mg; and Codeine 30mg. The medical records did not include a copy of the x-ray report. The progress report (PR-2) dated 10/20/2014 indicates that the injured worker complained of right knee pain awakening him at night, and right hip pain. The objective findings documented were hard to read due to illegibility. The injured worker's status was temporarily totally disabled. The injured worker rated his pain a 1 out of 10, with medications, and 9 out of 10, without medications. With the medications, he was able to perform his activities of daily living, there was improved participation in the home exercise program, and he had an improved sleep pattern. The treating physician requested Tylenol #3 for the treatment of chronic pain syndrome. On 11/13/2014, Utilization Review (UR) provided a modified certification for the request for Tylenol #3 #60, one (1) tablet by mouth every twelve (12) hours, as needed. The UR physician noted that there is no evidence that a signed pain agreement was on file at the provider's office or that a pain diary had been recommended, and was being kept by the injured worker and reviewed by the prescriber. The UR physician cited the MTUS Chronic Pain Guidelines and modified the request to Tylenol #3 #30 for weaning purposes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tylenol #3 #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 78-79.

Decision rationale: The request for Tylenol #3 is not medically necessary. Tylenol #3 contains codeine and acetaminophen. The chart does not provide any documentation of improvement in pain and function with the use of Tylenol #3. There are illegible progress notes in the chart. There are no documented urine drug screens or drug contracts, or long-term goals for treatment. The 4 A's of ongoing monitoring were not adequately documented. Because there was no documented improvement in pain or evidence of objective functional gains with the use of Tylenol #3, the long-term efficacy for chronic back pain is limited, and there is high abuse potential, the request is considered not medically necessary.