

Case Number:	CM14-0032929		
Date Assigned:	06/20/2014	Date of Injury:	11/09/2010
Decision Date:	01/22/2015	UR Denial Date:	02/14/2014
Priority:	Standard	Application Received:	03/14/2014

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 Internal Medicine, has a subspecialty in Rheumatology, Allergy & Immunology and is licensed to practice in Texas. 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 case involves a 45 year old female with a date of injury of 11/9/2010. She is being treated for cervical spine strain, bilateral carpal tunnel syndrome, bilateral lateral epicondylitis, anxiety reaction, dermatitis and bilateral shoulder impingement syndrome. Subjective complaints on 1/15/14 consisted of an increased amount of neck spasms, back spasms with decreased range of motion and increased numbness and tingling in her left wrist. Objective findings included paravertebral muscle tenderness to palpation with spasms and restricted range of motion. Positive impingement sign bilaterally and decreased range of motion was noted in both shoulders. The bilateral elbows were tender to palpation. Bilateral grip strength was reduced and sensation was reduced in bilateral median nerve distributions. A positive Phalen's and Tinel's sign was present bilaterally on examination of the bilateral wrists. The injured worker has been treated with physical therapy, wrist splints, acupuncture, rest and medications (Ketoprofen, Omeprazole, Medrox ointment, Norco and Cyclobenzaprine). On 2/14/14 the utilization review (UR) physician modified the request for Hydrocodone 5/325 2 tablets twice per day #120. The UR physician noted there did not appear to be evidence that the injured worker had returned back to work or had objective evidence of improved functioning. The UR physician also noted the Medical Treatment Utilization Schedule guidelines support the slow weaning and taper of medications. The request was modified to achieve an initial taper.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 5/325 2 tablets BID (Twice a day), # 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone; Opioids Page(s): 51; 74-95.

Decision rationale: Official Disability Guidelines (ODG) does not recommend the use of opioids for neck and 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." In this case, 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. Additionally, medical documents fail to document how long this patient has been on this opioid. The UR did receive access to the medication record from 2/11/13-2/11/14 and recommends a modification to wean her off opioids suggesting it was well in excess of the recommended 2-week limit. The treating physician does not detail sufficient information to substantiate the need for continued opioid medication. As such, this request is not medically necessary.