

Case Number:	CM15-0106981		
Date Assigned:	06/11/2015	Date of Injury:	11/24/2010
Decision Date:	11/30/2015	UR Denial Date:	06/02/2015
Priority:	Standard	Application Received:	06/03/2015

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: Arizona, California
 Certification(s)/Specialty: Family Practice

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 59 year old female who sustained an industrial injury November 24, 2010. Past history included transforaminal epidural steroid injections right L4, L5 and S1 February 22, 2015, (3) injections in 2013 and (1) in 2014. According to a treating physician's follow-up visit dated May 6, 2015, the injured worker reported improved symptoms in March of 2015, after the injections and the back pain had decreased. She had not been taking pain medication and lost some weight since the injection. She now reported leg pain somewhat controlled with Gabapentin, right upper neck pain with right hand cramps, numbness of the 3rd and 4th fingers and right shoulder tightness. The physician documents she has a rotator cuff tear and will be seeing another physician. Objective findings included; over 302 pounds; walking with assisted device (unspecified) positive hypersensitivity over the right L4 and L5 distribution; back-limited range of motion of the lower back with pain and tenderness and muscular tightness over the facet joints; straight leg raise positive right at 40 degrees, negative left; Patrick's negative bilaterally. Assessment is documented as degenerative spine disease with right lumbar radiculopathy. At issue, is the request for authorization for Tylenol #3. According to utilization review dated June 2, 2015, the request for Tylenol #3 Quantity: 50 Refills: (1) is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tylenol No. 3 #50 x 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids, specific drug list.

Decision rationale: Tylenol #3 contains codeine which is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Tylenol #3 for an unknown length of time. Pain scores were not noted. There was no mention of Tylenol (alone), NSAID, Tricyclic or weaning failure. The continued use of Tylenol #3 is not medically necessary.