

Case Number:	CM15-0133179		
Date Assigned:	07/21/2015	Date of Injury:	12/23/2009
Decision Date:	09/18/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	07/09/2015

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: New York, Pennsylvania, Washington
 Certification(s)/Specialty: Internal Medicine, Geriatric Medicine

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 39-year-old male injured worker suffered an industrial injury on 12/23/2009. The diagnoses included lumbosacral radiculitis, lumbar degenerative intervertebral disc, and chronic pain syndrome. The diagnostics included lumbar computerized tomography. The treatment included medication. On 4/22/2015, the treating provider reported the pain level had improved over the last month but was unable to attribute this to anything in particular. He reported continued trouble with ambulation and performing activities of daily living. On exam, the provider noted facial grimacing, sighing and slow gait with a walker. The provider noted that when the pain was addressed with surgery he would taper off the medication. He noted the CURES report, latest urine drug screen and controlled substances agreement and all were appropriate. The injured worker had not returned to work. The requested treatments included Retrospective (DOS: 06/02/2015): Hydrocodone/APAP Tab 10/325mg #240.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: Hydrocodone/APAP Tab 10/325mg #240 (DOS: 06/02/2015): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 74-80.

Decision rationale: Per the guidelines, in opioid use, ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects is required. Satisfactory response to treatment may be reflected in decreased pain, increased level of function or improved quality of life. The MD visit fails to document any significant improvement in pain, functional status or a discussion of side effects specifically related to opioids to justify use per the guidelines. Additionally, the long-term efficacy of opioids for chronic back pain is unclear but appears limited. The medical necessity of hydrocodone/APAP is not substantiated in the records.