

Case Number:	CM15-0165345		
Date Assigned:	09/02/2015	Date of Injury:	03/18/2004
Decision Date:	10/06/2015	UR Denial Date:	08/03/2015
Priority:	Standard	Application Received:	08/24/2015

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 51 year old male, who sustained an industrial injury on March 18, 2004. He reported injury to the low back. The injured worker was diagnosed as having chronic pain syndrome, degeneration of lumbar or lumbosacral intervertebral disc, postlaminectomy syndrome of lumbar region, lumbago, thoracic or lumbosacral neuritis or radiculitis unspecified and long-term use of other medications. Treatment to date has included diagnostic studies, psychiatric evaluation, physical therapy and medications. Currently, the injured worker complained of back pain with radiation to the bilateral lower extremities. The pain was rated as a 10 on a 1-10 pain scale and as a 5 on the pain scale with medications. The treatment plan included medications. A request was made for Hydrocodone-Acetaminophen 10-325 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone-Acetaminophen 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 82-92.

Decision rationale: Hydrocodone 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 Hydrocodone for over 6 months. There was no mention of Tylenol, NSAID, or weaning failure. The continued use of Hydrocodone is not medically necessary.