

Case Number:	CM15-0183261		
Date Assigned:	09/24/2015	Date of Injury:	10/04/2000
Decision Date:	11/06/2015	UR Denial Date:	09/10/2015
Priority:	Standard	Application Received:	09/17/2015

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: California, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 64 year old female who sustained an industrial injury on 10-04-2000. Current diagnoses include muscle spasm, lumbar spondylosis, and lumbar radiculopathy. Report dated 08-24-2015 noted that the injured worker presented for follow up. The physician noted that the injured worker has completed the program and has yet to receive her equipment. The injured worker states that she uses hydrocodone with good effect. Pain level was not included. No physical examination was performed on 08-24-2015. Previous treatments included medications and [REDACTED]. The treatment plan included returning to clinic every month for medications, refilled hydrocodone and Paxil, and return for follow up visit in 3 months. Work status was documented as temporarily totally disabled and currently not working. Request for authorization dated 09-04-2015, included requests for hydrocodone-acetaminophen and Paxil. The utilization review dated 09-10-2015, non-certified the request for hydrocodone-acetaminophen and Paxil.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 5-325 MG #30 with 0 Refills: 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.

Decision rationale: The patient presents with muscle spasm, lumbar spondylosis, and lumbar radiculopathy. The current request is for Hydrocodone/APAP 5-325 mg #30 with 0 refills. The treating physician states, in a report dated 04/24/15, "Refill of: Hydrocodone/Acetaminophen 5mg/325mg Tablet 1 at bedtime #30 (Thirty) tablet(s) Refills: 0". (17B) The MTUS guidelines for opioid usage state that Hydrocodone is an option for treating pain. There is no documentation of what the current pain levels are. MTUS pgs 88, 89 requires documentation of pain and functional improvement compared to baseline. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument. MTUS further requires documentation of the four A's (analgesia, ADL's, adverse side effects, adverse behavior). In this case, there are no reports that document pain assessment and function related to opiate use. There is no documentation of numeric scale assessing the patient's function. No Analgesia, ADL's or other measures are provided regarding the use of Hydrocodone. As stated in the current reports, one cannot tell that Hydrocodone has done anything for this patient's pain and function. The current request is not medically necessary.

Paxil 10 MG #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Mental Illness & Stress, Paroxetine (Paxil®).

Decision rationale: The patient presents with muscle spasm, lumbar spondylosis, and lumbar radiculopathy. The current request is for Paxil 10 MG #30. The treating physician states, in a report dated 04/24/15, "Refill of: Paxil 10 mg per day". (17B) The MTUS guidelines are silent on the issue of Paxil. ODG guidelines state, "Recommended as a first-line treatment option for major depressive disorder and PTSD". In this case, the treating physician, based on the records available for review, has not documented either a major depressive disorder or PTSD. There is nothing in the reports available for review to suggest that the patient is suffering from any kind of depression. The current request is not medically necessary.