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| Case Number: | CM15-0195962 | | |
| Date Assigned: | 10/09/2015 | Date of Injury: | 07/22/1996 |
| Decision Date: | 11/18/2015 | UR Denial Date: | 09/17/2015 |
| Priority: | Standard | Application Received: | 10/05/2015 |

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 injured worker is a 55 year old male, who sustained an industrial injury on 7-22-96. The injured worker is diagnosed with post spinal fusion arthrodesis. His work status is regular duty. Notes dated 7-27-15 - 9-8-15 reveals the injured worker presented with complaints of moderate back pain with intermittent radiation to his hips and legs (left greater than right) described as cramping and spasms. Physical examinations dated 6-11-15 - 9-8-15 revealed mildly positive straight leg raising, slight lumbar spasm and slight limitations of lumbar range of motion. His medication regimen has included; Norco (discontinued), Ultram (discontinued) and Tylenol #3 (10 months), which is therapeutically efficacious per note dated (9-8-15); surgical intervention; L5-S1 anterior lumbar interbody fusion with posterior pedicle screw fixation and left L4-L5 Polar with removal of the Sextant instrumentation, revision of the L4-S1 and fusion. Diagnostic studies to date have included lumbar spine MRI (2012), CT myelogram and lumbar x-ray. A request for authorization dated 9-10-15 for Tylenol #3, #60 with 1 refill is modified to #48 with 0 refill, per Utilization Review letter dated 9-17-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tylenol No.3, #60 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, long-term assessment.

Decision rationale: Tylenol No.3, #60 with 1 refill is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS Chronic Pain Medical Treatment Guidelines state that a 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. The MTUS does not support ongoing opioid use without improvement in function or pain. The documentation submitted does not reveal the above pain assessment or clear monitoring of the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors). The documentation does not reveal an objective urine toxicology screen. The documentation reveals that the patient has been on long term opioids without significant functional improvement therefore the request for continued Tylenol No. 3 is not medically necessary.