

Case Number:	CM15-0020694		
Date Assigned:	02/10/2015	Date of Injury:	06/06/2002
Decision Date:	03/25/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	02/04/2015

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: Georgia
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 57-year-old female, with a reported date of injury of 06/06/2002. The diagnoses include brachial neuritis or radiculitis, cervical radiculopathy, and left neck pain. Treatments have included oral medications, and topical pain medication. The progress report dated 01/20/2015 indicates that the injured worker had pain over the left side of the neck and into her left shoulder. She had some left radiculopathy. It was noted that the injured worker was controlled on the current regimen and had not increased in the use of narcotics for years. The physical examination showed minimal weakness in the left upper extremity. The treating physician requested hydrocodone/acetaminophen 10/325mg #140, one tablet by mouth every 6 hours as needed for pain. On 01/28/2015, Utilization Review (UR) denied the request for hydrocodone/acetaminophen 10/325mg #140, noting that there was no documentation of an assessment of pain relief or functional benefit of long-term opioid therapy. The MTUS Chronic Pain Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Hydrocodone/Acetaminophen 10/325mg #140: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, and Criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 79.

Decision rationale: 1 prescription of Hydrocodone/Acetaminophen 10/325 mg # 140 is not medically necessary. Per MTUS Page 79 of MTUS guidelines states that weaning of opioids are recommended if; (a) there are no overall improvement in function, unless there are extenuating circumstances. (b) continuing pain with evidence of intolerable adverse effects. (c) decrease in functioning. (d) resolution of pain. (e) if serious non-adherence is occurring. (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. The claimant has long-term use with this medication and there was a lack of improved function with this opioid; therefore, the requested medication is not medically necessary.