

Case Number:	CM15-0027344		
Date Assigned:	02/19/2015	Date of Injury:	10/02/1993
Decision Date:	03/30/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	02/13/2015

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 injured worker is a 66 year old male, who sustained an industrial injury on 10/2/1993. The mechanism of injury and initial injuries were not provided for review. Diagnoses include lumbar facet arthropathy, lumbar disc syndrome, muscle spasm, lumbar radiculopathy, myofascial pain and status post left knee arthroscopy and lumbar 5-sacral 1 fusion with one sided failure. Treatments to date include surgery, therapy and medication management. A progress note from the treating provider dated 1/20/2015 indicates the injured worker reported increasing low back pain with right lower extremity pain and left leg pain and numbness. On 2/4/2015, Utilization Review non-certified the request for Hydrocodone/Acetaminophen 7.5/325mg #60 for 30 day supply, citing MTUS.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/Acetaminophen 7.5-325 #60 for 30 day supply: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management of Opioid Use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 ? 9792.26 Page(s): 74-80.

Decision rationale: This injured worker has chronic pain with an injury sustained in 1993. The medical course has included numerous treatment modalities including surgery and use of several medications including narcotics, muscle relaxants and gabapentin. 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 of 1/15 fails to document any significant improvement in pain, functional status or a discussion of side effects specifically related to Hydrocodone/Acetaminophen 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/Acetaminophen is not substantiated in the records.