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| Case Number: | CM15-0221773 | | |
| Date Assigned: | 11/17/2015 | Date of Injury: | 10/25/2001 |
| Decision Date: | 12/30/2015 | UR Denial Date: | 10/13/2015 |
| Priority: | Standard | Application Received: | 11/11/2015 |

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 68 year old male, who sustained an industrial injury on 10-25-2001. He reported moderate to severe low back pain, right leg pain with numbness and tingling that extended to the right foot. According to physician documentation, the injured worker was diagnosed with degenerative disc disease and facet spondylosis of the lumbar spine at L3-L4, L4-L5, (lumbar) and L5-S1 (sacral), status post L5-S1 fusion associated with instability at L3-L4 and L4-L5 as well as right lower extremity radiculitis. Subjective findings dated 8-18-2015, were notable for continued low back pain with some right and left leg pain, where he states, he had a flare-up July 2015 without any re-injury experiencing onset of left leg pain that radiated to his left foot. Also stating, his left leg pain resolved but the low back pain is constantly moderate to severe. Objective findings dated 8-18-2015, were notable for cervical spine range of motion 35 degree flexion, 20 degree extension, 20 degree right rotation, 25 degree left rotation, 10 degree right and left bending, with upper extremities having deep tendon reflexes of 2+symmetrical at biceps, 1+ symmetrical at triceps. Treatments to date have included injections, Butrans patch 20mcg, Topamax 50mg, Gabapentin 600mg, Soma 350mg and Norco 10/325mg (since at least 8-18-2015). The Utilization Review determination dated 10-25-2015 did not certify treatment/service requested for Hydrocodone/Apap 10/325mg. Supply: 6, Qty: 50.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydroco/APAP Tab 10-325 MG 6 Day Supply Qty 50 with No Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: 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 fails to document any significant improvement in pain, functional status or a discussion of side effects specifically related to opioids 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 is not substantiated in the records. The request is not medically necessary.