

Case Number:	CM15-0051332		
Date Assigned:	03/24/2015	Date of Injury:	10/31/1996
Decision Date:	05/01/2015	UR Denial Date:	02/19/2015
Priority:	Standard	Application Received:	03/18/2015

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: Arizona, California
 Certification(s)/Specialty: Family Practice

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 male, who sustained an industrial injury on 10/31/1996. The mechanism of injury was not noted. The injured worker was diagnosed as having lumbar spine signs and symptoms with bilateral lower extremity radiculopathy, multi-level degenerative disc disease L4-S1, and retrolisthesis L5 on S1. Treatment to date has included medications and physical therapy. The supplemental report, dated 10/06/2014, noted an initial exam on 1/04/2013, for complaints of low back pain. A follow-up appointment on 8/08/2014 was documented and the injured worker reported that he tried to return to work but was unable to perform his usual duties. Physical examinations were not described. Current medication use was not described. Previous diagnostic testing results were not noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone / Acetaminophen 10/325mg Qty: 60 for 20 day supply: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids
 Page(s): 82-92.

Decision rationale: Hydrocodone is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, length of prior Hydrocodone was not provided. Failure of Tylenol use was not noted. Details of the physical exam were not substantiated. The continued use of Hydrocodone is not medically necessary.