

Case Number:	CM15-0054299		
Date Assigned:	03/27/2015	Date of Injury:	05/03/2006
Decision Date:	05/04/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	03/23/2015

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 54-year-old male, who sustained an industrial injury on 05/03/2006. On provider visit dated 01/30/2015 the injured worker has reported low back pain with right greater than left extremity symptoms, right knee pain and left ankle pain. On examination of the lumbar spine it was noted to have tenderness and decreased range of motion. Positive straight leg raise bilaterally. Right knee was noted as having tenderness and crepitus on range of motion with a slight antalgic gait. Left ankle tenderness was noted to medial and lateral aspect, swelling and guarding noted. The diagnoses have included status post remote lumbar decompression 12/2012, lumbar spondylosis, and lumbar radiculopathy, right knee pain rule out internal derangement, left ankle pain rule out osteochondral defect/chronic sprain/strain and generalized abdominal discomfort rule out industrial causation. Treatment to date has included medication, physical therapy, MRI of the left side, right knee brace, internal medicine consultation, and back brace. The provider requested pain medication Hydrocodone for symptom management.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 7.5mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management Page(s): 78-80.

Decision rationale: Hydrocodone 7.5mg #60 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The documentation submitted does not reveal clear monitoring of the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The patient had inconsistent urine drug screens on 11/19/14 and 2/4/15 that were negative for prescribed opioids. This is no accordance with the MTUS Guidelines and therefore this request is not medically necessary.