

Case Number:	CM15-0061209		
Date Assigned:	04/07/2015	Date of Injury:	01/16/2013
Decision Date:	05/08/2015	UR Denial Date:	03/04/2015
Priority:	Standard	Application Received:	03/31/2015

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: California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 56 year old male, who sustained an industrial injury on January 16, 2013. The injured worker had reported mid and lower back pain. The diagnoses have included displacement of lumbar intervertebral disc without myelopathy, thoracic disc displacement, extremity neuritis, lumbar disc protrusion and lumbar myofascitis. Treatment to date has included medications, radiological studies, physical therapy, acupuncture therapy and a psychological evaluation. Current documentation dated February 16, 2015 notes that the injured worker reported severe upper, mid and low back pain. Examination of the thoracic spine revealed no change since the last visit. Range of motion was noted to be decreased. Lumbar spine examination revealed increased pain due to lack of medications and a decreased range of motion. A straight leg raise test was positive on the right. The treating physician's plan of care included a request for Tylenol # 3 #90 as needed for pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

TYLENOL #3 300-30MG #90, TID: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 11.

Decision rationale: According to the MTUS, acetaminophen is recommended for treatment of chronic pain & acute exacerbations of chronic pain. There has been some discussion lately in regard to the dose of acetaminophen, but it is recommended by the MTUS for acute and chronic pain except in those with liver disease. The patient is not taking any other narcotics or NSAID's in addition to the prescribed Tylenol and is following a responsible dosage regimen. I am reversing the previous utilization review decision. TYLENOL #3 300-30MG #90 is medically necessary.