

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0136022 | | |
| Date Assigned: | 09/03/2014 | Date of Injury: | 04/02/2012 |
| Decision Date: | 10/27/2014 | UR Denial Date: | 07/22/2014 |
| Priority: | Standard | Application Received: | 08/22/2014 |

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 28 year-old male with date of injury 04/0/2012. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 07/09/2014, lists subjective complaints as mid to lower back pain with numbness and tingling in the bilateral lower extremities. Patient is status post bilateral microlumbar decompression surgery at L5-S1 on 08/14/2013. Objective findings: Patient had mildly antalgic gait. His heel and toe walk was normal. There was minimal tenderness to palpation of the lumbar paraspinals and on the midline. Range of motion of the lumbar spine was decreased in all planes. Lower extremity sensation was intact bilaterally. Motor exam was 5-/5 for bilateral tibialis anterior, 4+/5 left EHL, 5-/5 right EHL, 5-/5 bilateral inversion, plantarflexion and eversion. Diagnosis: 1. Status post microlumbar decompression 2. HNP of the thoracic spine 3. Lumbar radiculopathy. The medical records provided for review document that the patient has been taking the following medication for at least as far back as 08/14/2013. Medications: 1. Hydrocodone/ APAP 10/325mg, #90 SIG: b.i.d. as needed for pain

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-94.

Decision rationale: A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of narcotics, the patient has reported very little, if any, functional improvement or pain relief over the course of the last year.