

Case Number:	CM14-0145426		
Date Assigned:	09/12/2014	Date of Injury:	03/06/1996
Decision Date:	10/16/2014	UR Denial Date:	08/29/2014
Priority:	Standard	Application Received:	09/08/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Texas and Ohio. 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 injured worker is a 56 year old female who reported injury on 06/06/1999 due to getting hit from behind while driving. The diagnoses included left low back, hip, left leg pain, left and right trapezius spasm and piriformis syndrome. Past treatments medications. There was no diagnostic and surgical history provided. On 01/21/2014 the injured worker complained of left low back, hip and left leg pain. The physical exam findings included 2-3 positive spasm in the left and right trapezius, 3 positive spasm in the left piriformis, her neurological findings were grossly intact, her back pain was 2 % and piriformis syndrome. Medications included Norco 10/325mg. The treatment plan was Norco 10/325mg and to follow up in one month. The rationale for the request and the request for authorization form was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 10/325 #90: 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): 78.

Decision rationale: The request Hydrocodone/APAP 10/325 #90 is not medically necessary. The injured worker has a history of left low back, hip, left leg pain, and left and right trapezius spasm and piriformis syndrome. The California Medical Treatment Utilization Schedule (MTUS) guidelines state for opioid ongoing management there should be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since the last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Furthermore, guidelines recommend that dosing not exceed 120 mg of oral morphine equivalents per day, and for those taking more than one opioid, the morphine equivalent doses of the different Opioids must be added together to determine the cumulative dose. Moreover, the use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control should be used for monitoring purposes for ongoing management of opioid use. The injured worker complained of left low back, hip and left leg pain. There is a lack of documentation indicating the injured worker was assessed for aberrant behaviors. There is a lack of documentation indicating when the injured worker last underwent a urine drug screen. The requesting physician did not provide documentation of an adequate and complete assessment of the injured worker's pain. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. Furthermore, the frequency, was not provided in the request. Therefore the request is not supported. As such, the request Hydrocodone/APAP 10/325 #90 is not medically necessary.