

Case Number:	CM14-0168437		
Date Assigned:	10/16/2014	Date of Injury:	05/11/2012
Decision Date:	11/18/2014	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	10/13/2014

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 Pain Management 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 injured worker is a 61-year-old male who sustained an injury on May 11, 2012. He is diagnosed with status post meniscal repair of right knee with instability. He was seen for an evaluation on September 9, 2014. He had complaints of intermittent pain in the low back, which was described as dull, achy, tight, and stiffness. The pain was rated 5/10. He reported that he continued to be symptomatic, off and on, and that it traveled down to the right posterior lower extremity. He also reported constant pain in the knee, which was described as dull and achy. The pain was rated 5/10. Examination of the lumbar spine revealed tenderness and spasms bilaterally, right side greater than left. Range of motion was limited by pain and spasms. Positive Kemp's test was noted. Straight leg raising test was positive at 40 degrees on the right side and at 60 degrees on the left side. Reflexes for the knees were normal bilaterally. There was no loss of sensibility, abnormal sensation, or pain in the bilateral dermatomes. Examination of the right knee revealed nonspecific tenderness at the medial collateral and lateral collateral on the right. McMurray's test with interior and exterior rotation was positive on the right knee. Right knee range of motion was limited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/Acetaminophen 10/325 mg #120 (times 1 refill): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 76-77.

Decision rationale: The request for Hydrocodone/Acetaminophen 10/325 mg #120 (times 1 refill) is not medically necessary at this time. Guidelines state that to warrant continued use of opioid medications, the injured worker should have returned to work and/or there is evidence of improved pain and functioning. In this clinical case, the injured worker has satisfied neither of these conditions.