

Case Number:	CM14-0179316		
Date Assigned:	11/03/2014	Date of Injury:	03/13/2001
Decision Date:	12/17/2014	UR Denial Date:	10/14/2014
Priority:	Standard	Application Received:	10/28/2014

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 & Rehabilitation 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 58-year-old male who reported an injury on 03/13/2001. The mechanism of injury was not provided. His diagnoses were listed as upper back strain, status post bilateral knee surgeries, moderate disc herniation at L4-5 and L5-S1, and cervical degeneration at C4-5 and C5-6. Past treatments included medications, work modifications, and surgery. His surgical history included surgery of the bilateral knees. On 08/21/2014, the injured worker complained of mid to low back pain. The physical examination of the lumbar spine revealed restricted range of motion, and tenderness to palpation in the lumbar paraspinal and thoracic paraspinal regions. His current medications were not provided. The treatment plan included a referral for physical therapy 3 times 4 and medications. A request was received for Hydrocodone 10/325 mg, 120 count; and Thermacare pads, 30 count with 1 refill. The rationale for the request was not provided. The Request for Authorization form was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 10/325 mg, #120: 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): 77.

Decision rationale: The request for Hydrocodone 10/325 mg, #120 is not medically necessary. The California MTUS Guidelines state that ongoing use of opioids should include documentation of pain assessments, functional status, appropriate medication use, and adverse side effects. Pain assessments should include current pain; the least reported pain; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long the relief lasts. The clinical notes indicated that the injured worker was prescribed Norco 10/325 mg on 08/21/2014. However, there was no documentation of pain assessments, functional status, appropriate medication use, or adverse side effects. In the absence of documentation to indicate the ongoing use of opioids as appropriate, the request is not supported. In addition, the request does not specify the frequency of use. As such, the request is not medically necessary.

Thermacare pads, count thirty with one refill: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: The request for Thermacare pads, count 30 with 1 refill is medically necessary. The California MTUS Guidelines recommend heat therapy as an option for pain reduction and a return to normal function. The clinical notes indicated that the injured worker complained of mid to low back pain and difficulty following his home exercise program. In addition, the guidelines also state that there is moderate evidence that heat wrap therapy provides short term reduction in pain and disability, and that the addition of exercise further reduces pain and improves function. As there is evidence that the injured worker participates in a home exercise program, the request is supported. Therefore, the request is medically necessary.