

Case Number:	CM14-0068315		
Date Assigned:	07/14/2014	Date of Injury:	01/28/2002
Decision Date:	06/10/2015	UR Denial Date:	04/29/2014
Priority:	Standard	Application Received:	05/13/2014

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. 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: Emergency 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 62 year old female, who sustained an industrial injury on 01/28/2002. She has reported subsequent neck, back, left shoulder and left knee pain and was diagnosed with lumbar and cervical spondylosis, lumbago, cervicgia, sacroiliitis and myofascial pain syndrome. Treatment to date has included oral and topical pain medication, cervical steroid injections, chiropractic therapy and acupuncture therapy. In a progress note dated 02/10/2015, the injured worker complained of left shoulder and left lower extremity pain. Objective findings were notable for tenderness to palpation along the left sided cervical paraspinal muscles, trapezial, rhomboid and periscapular muscles, tenderness to palpation along the left sided mid to lower lumbar paraspinal muscles and left sided sacroiliac joint. A request for authorization of Hydrocodone/APAP was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective DOS: 3/5/14:1 prescription for Hydrocodone/APAP 7.5/325mg #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; Norco; Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82 Page(s): 78-82.

Decision rationale: The requested Retrospective DOS: 3/5/14:1 prescription for Hydrocodone/APAP 7.5/325mg #60 with 2 refills is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has left shoulder and left lower extremity pain. Objective findings were notable for tenderness to palpation along the left sided cervical paraspinal muscles, trapezial, rhomboid and periscapular muscles, tenderness to palpation along the left sided mid to lower lumbar paraspinal muscles and left sided sacroiliac joint. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, or measures of opiate surveillance including an executed narcotic pain contract or urine drug screening. The criteria noted above not having been met, Retrospective DOS: 3/5/14: 1 prescription for Hydrocodone/APAP 7.5/325mg #60 with 2 refills, is not medically necessary.