

Case Number:	CM15-0118025		
Date Assigned:	06/26/2015	Date of Injury:	12/13/1991
Decision Date:	07/31/2015	UR Denial Date:	05/15/2015
Priority:	Standard	Application Received:	06/18/2015

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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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 an 86 year old female who sustained an industrial injury on December 13, 1991. She has reported low back pain that radiates down the right lower extremity left greater than right and has been diagnosed with lumbar disc displacement, lumbar facet arthropathy, lumbar radiculopathy, left ankle pain, chronic pain, status post left ankle surgery, and left trigger thumb. Treatment has included surgery and medications. There was spasm noted in the right paraspinous musculature. Tenderness was noted upon palpation in the right paravertebral area L3-5 levels. The range of motion of the lumbar spine was moderately limited secondary to pain. Pain was significantly increased with flexion and extension. Sensory exam showed decreased sensitivity to touch in the right lower extremity. Straight leg raise with the patient in the seated position was positive on the left for radicular pain at 70 degrees and on the right for radicular pain at 60 degrees. Pain was rated as 3-4-5/10 on average with medications since last visit and a 5-6-7-8-9/10 on average without medications since last visit. The treatment request included hydrocodone 10/325mg # 90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP (acetaminophen) 10/325 mg QTY: 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, Hydrocodone Page(s): 44, 47, 75-79, 120.

Decision rationale: Regarding the request for hydrocodone/acetaminophen, California Pain Medical Treatment Guidelines state that hydrocodone is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested hydrocodone/acetaminophen is not medically necessary.