

Case Number:	CM15-0026701		
Date Assigned:	02/19/2015	Date of Injury:	04/18/2002
Decision Date:	04/14/2015	UR Denial Date:	01/29/2015
Priority:	Standard	Application Received:	02/12/2015

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 57-year-old female, who sustained an industrial injury on April 18, 2002. The diagnoses have included cervical radiculitis, status post cervical spinal fusion, lumbar radiculopathy, anxiety, depression, and insomnia. Treatment to date has included pool therapy, TENS, home exercise program, and medications. Currently, the injured worker complains of neck pain that radiates down the right upper extremity, pain radiating to the right shoulder, elbow, and forearm, low back pain, upper extremity pain, and lower extremity pain. The Treating Physician's report dated January 22, 2015, noted the cervical examination to show spinal vertebral tenderness in C4-C6, with tenderness to palpation at the bilateral paravertebral C4-C6 area, with range of motion (ROM) moderately limited due to pain. The lumbar examination was noted to show spasm, tenderness to palpation in the bilateral paravertebral area L4-S1 levels and in the spinal vertebral area L4-S1 levels, with range of motion (ROM) moderately limited due to pain. On January 29, 2015, Utilization Review non-certified one prescription of Hydrocodone 10/325mg #120 and one prescription of Oxycontin 40mg #90. The UR Physician noted that despite treatment since 2012, the provided records did not demonstrate significant pain relief or functional improvement that could be attributed to its use, therefore the request for one prescription of Hydrocodone 10/325mg #120 was non-certified. The UR Physician noted that previous weaning of the Oxycontin was halted to allow the injured worker to safely discontinue Hydrocodone/Acetaminophen, therefore, the request for one prescription of Oxycontin 40mg #90 was modified for approval of #33 with the remaining #57 non-certified. The MTUS Chronic Pain Medical Treatment Guidelines was cited. On February 12, 2015, the

injured worker submitted an application for IMR for review of one prescription of Hydrocodone 10/325mg #120 and one prescription of Oxycontin 40mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Hydrocodone 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management Page(s): 78-80.

Decision rationale: 1 prescription of Hydrocodone 10/325mg #120 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, and return to work. The MTUS states that satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. The documentation submitted reveals that the patient has been on long-term opioids without significant functional improvement therefore the request for 1 prescription of Hydrocodone 10/325mg #120 is not medically necessary.

1 prescription of Oxycontin 40mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management Page(s): 78-80.

Decision rationale: 1 prescription of Oxycontin 40mg #90 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, and return to work. The MTUS states that satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. The documentation submitted reveals that the patient has been on long-term opioids without significant functional improvement therefore the request for 1 prescription of Oxycontin 40mg #90 is not medically necessary.