

Case Number:	CM15-0090670		
Date Assigned:	05/15/2015	Date of Injury:	01/17/2013
Decision Date:	06/17/2015	UR Denial Date:	04/11/2015
Priority:	Standard	Application Received:	05/11/2015

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: New Jersey, New York
 Certification(s)/Specialty: Family Practice

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 51 year old male who sustained an industrial injury on 01/17/2013. The mechanism of injury was while standing the injured worker fainted and fell backward. Diagnoses include status post traumatic head injury with intracranial bleed/contusion, post traumatic headaches, dizziness, and disequilibrium, cervical sprain, cervical radiculopathy-left greater than right, lumbosacral sprain, chronic myofascial pain, lumbar spine region, post-concussion syndrome and post traumatic mixed hearing loss on the right side. Medications include Motrin, Nortriptyline, Cymbalta, and Ultram. A Magnetic Resonance Imaging of the cervical spine dated 05/18/2013 revealed no significant abnormalities detected along the course of the cervical cord or imaged portion of the upper thoracic cord as seen to the upper T4 level. There are no contusional changes detected within the cord and no evidence of syrinx or myelopathy. There is diffuse straightening of the cervical lordotic curvature that could in part be related to neck muscle spasm and /or degenerative disk disease, however, there may be some subtle scoliotic curvature of the cervical spine extending into the upper thoracic spine for which correlation with plain film scoliotic series may be helpful as clinically indicated. A Magnetic Resonance Imaging of the lumbar spine done on 05/18/2013 revealed mild disc bulging with no obvious stenosis observed at T11-T12, T12-L4 and L1-L2. At L4-L5 there is moderate right lateral disk bulging versus broad-based protrusion at the mid to outer neural foramen measuring 4-5 mm in thickness with bright heterogeneous signal along the disk periphery suggestive of prominent right lateral and far right lateral annular tear. At L5-S1 there is very mild posterior annular disk bulging/diffuse endplate spurring with a superimposed small to moderate sized,

broad based central protrusion suspicious for a contained herniation measuring 3-4 mm in thickness with slight caudal extension of disk material in the midline. Treatment to date has included medications, diagnostic studies, trigger point injections, chiropractic treatment, and home exercise program. A physician progress note dated 03/18/2015 documents the injured worker reported his back is getting worse. He rates his pain at a 9-10 out of 10 for the past week. His back pain radiates to both hips. When walking he swings his hips and he has severe back pain, and his gait is guarded and antalgic. He has difficulty sleeping due to pain. He has headaches. Due to increased pain he is taking Motrin 3 times a day and it is upsetting his stomach. He was limping and could barely walk. On examination there is marked tenderness and myofascial pain over the lumbosacral region. There was hypertonicity and muscle spasm of the lumbar paraspinals and gluteus on both sides. Lumbar range of motion is restricted. Straight leg raising test was restricted at 60 degrees with pain spreading down the right posterior leg. He has tenderness and myofascial pain over the bilateral sub occipital and lateral cervical region. Cervical range of motion was restricted. He was anxious and depressed. He has mild hearing loss in the right. There was weakness of the right hip flexors. There was impaired sensation diffusely in the right lower extremity. Due to his severe pain interfering with functioning level, trigger point injections, and a Toradol intramuscular injection were given on this visit. The treatment plan includes prescription for Nortriptyline to help with the chronic pain, post-traumatic headaches and sleep disturbances, Pepcid for NSAID induced stomach pain, Vicodin for pain, and chiropractic treatment due to the flare-up of back pain which is exceeding his tolerance level and affecting all aspects of his activities of daily living. Treatment requested is for Vicodin 5 mg #60 with 6 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vicodin 5 mg #60 with 6 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 13-16, 68, 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-79.

Decision rationale: The request for Vicodin is not medically necessary. The patient has been on opiates without objective documentation of the improvement in pain. There is no documentation of what his pain was like previously and how much Vicodin decreased his pain. There is no documentation of the four As of ongoing monitoring: pain relief, side effects, physical and psychosocial functioning, and aberrant drug-related behaviors. There are no urine drug screens or drug contract documented. There are no clear plans for future weaning, or goal of care. Because of these reasons, the request for Norco is not medically necessary.