

Case Number:	CM15-0097878		
Date Assigned:	05/28/2015	Date of Injury:	01/29/2004
Decision Date:	06/29/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/20/2015

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

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 67 year old female with an industrial injury dated 1/29/2004. The injured worker's diagnoses include lumbar disc with radiculitis, myalgia, degeneration of lumbar disc, cervical disc with radiculitis, degeneration of cervical disc, low back pain, cervicalgia, carpal tunnel syndrome and epicondylitis. Treatment consisted of Magnetic Resonance Imaging (MRI) of lumbar spine, X-ray, Electromyography (EMG), prescribed medications, physical therapy, water therapy, acupuncture, epidural injections, cervical fusion at C5-7 in May of 2006, and periodic follow up visits. In a progress note dated 4/21/2015, the injured worker reported neck and low back pain. The injured worker rated pain 3-4/10. Objective findings revealed spasm and guarding in right trapezius, limited cervical range of motion with pain, and diminished sensation in left upper extremity. The treating physician prescribed Hydrocodone-Acetaminophen 10/325mg tablet #180 now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone-Acetaminophen 10 per 325mg tablet #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80, 91, 124.

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

Decision rationale: The requested Hydrocodone-Acetaminophen 10 per 325mg tablet #180, 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 neck and low back pain. The injured worker rated pain 3-4/10. Objective findings revealed spasm and guarding in right trapezius, limited cervical range of motion with pain, and diminished sensation in left upper extremity. 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, nor measures of opiate surveillance including an executed narcotic pain contract or urine drug screening. The criteria noted above not having been met, Hydrocodone-Acetaminophen 10 per 325mg tablet #180 is not medically necessary.