

<b>Case Number:</b>	CM13-0056434		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	12/14/2007
<b>Decision Date:</b>	05/22/2014	<b>UR Denial Date:</b>	11/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/22/2013

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Texas and Oklahoma. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 42-year-old male who reported an injury on 12/14/2007. The mechanism of injury was not stated. Current diagnoses include lumbar radiculopathy, multilevel disc herniation in the lumbar spine with severe stenosis, status post micro lumbar decompressive surgery on 01/25/2011, and status post micro lumbar decompressive surgery bilaterally on 07/25/2013. The injured worker was evaluated on 09/11/2013. The injured worker reported an improvement in symptoms following the most recent surgery. Current medications include hydrocodone and Soma. Physical examination revealed an antalgic gait, a dry and intact midline incision, and tenderness to palpation of the lumbar spine. Treatment recommendations included continuation of current medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**HYDROCODONE/APAP 10/325MG #135 (RETROSPECTIVE):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SECTION ON OPIOIDS - SPECIFIC DRUG LIST: HYDROCODONE/ACETAMINOPHEN.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SECTION ON OPIOIDS Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the injured worker has utilized hydrocodone 10/325 mg since 05/2011. There is no documentation of objective functional improvement as a result of the ongoing use of this medication. There is also no frequency listed in the current request. Therefore, the request is not medically appropriate. As such, the request is non-certified.