

<b>Case Number:</b>	CM13-0068845		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	02/11/2004
<b>Decision Date:</b>	05/29/2014	<b>UR Denial Date:</b>	12/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/20/2013

### 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 & Rehabilitation and is licensed to practice in Illinois. 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 44-year-old female who reported an injury on 02/11/2004, secondary to a fall. The current diagnoses include right cervical radiculopathy, status post C5-6 fusion, right shoulder impingement syndrome, C6-7 disc degeneration with foraminal stenosis, disc space narrowing at L5-S1, right greater trochanteric bursitis, and status post anterior cervical discectomy and fusion at C6-7 on 06/26/2013. The injured worker was evaluated on 11/13/2013. The current medications include Norco 10/325 mg and Zanaflex 4 mg. The injured worker reported 8/10 lower back and neck pain. Physical examination revealed tenderness to palpation of the lumbosacral junction, tenderness over the right greater trochanter, intact sensation, 2+ deep tendon reflexes, and 5/5 motor strength in the bilateral lower extremities. The treatment recommendations at that time included continuation of current medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **PHARMACY PURCHASE OF HYDROCODONE/APAP 10/325MG #180: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Opioids, criteria for use.

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

**Decision rationale:** The 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. The injured worker has utilized Norco 10/325 mg since 08/2013. There is no evidence of objective functional improvement. The injured worker continues to report 8/10 pain. There is also no frequency listed in the current request. As such, the request is non-certified.