

<b>Case Number:</b>	CM14-0011711		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	07/18/2011
<b>Decision Date:</b>	07/25/2014	<b>UR Denial Date:</b>	01/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/29/2014

### 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 Occupational Medicine and is licensed to practice in California. 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 patient is a 50-year-old male who has submitted a claim for neck pain, thoracic pain, low back pain, leg pain, costovertebral osteoarthritis, thoracic vertebral fracture, lumbar mechanical pain, vertebral fracture, chronic pain, closed head injury, lumbar discogenic pain, lumbar strain/sprain, leg length discrepancy and scoliosis associated with an industrial injury date of 7/18/2011. Medical records from 2013 were reviewed which revealed constant back pain with radiation into the right lower extremity. Aggravating factors include, sitting, repetitive movements and walking if prolonged. Pain scale was 4/10. Physical examination showed thoracic spine to be grossly stiff in the cervicothoracic region. Slightly kyphosis for stance and gait was noted. Abduction and elevation of upper extremities were limited secondary to pain. Treatment to date has included, spinal fusion of thoracolumbar, shoulder arthroscopy, rotator cuff repair left side, femoral rodding, external right leg fixation, TENS and physical therapy. Medications taken include, Ketoprofen, Cyclobenzaprine, Meloxicam, Norco, Topiramate and Omeprazole. Utilization review from 1/2/14 modified the request for Hydrocodone 2.5/325 mg (Norco) for weaning purposes.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone 2.5/325 (norco), 1 tablet by mouth up to 3 x daily as needed for pain control #60, plus one refill:** Upheld

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

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

**Decision rationale:** As stated on page 78 of the MTUS Chronic Pain Medical Treatment Guidelines, four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potential aberrant (or non-adherent) drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, the earliest progress report stating the patient's usage of Hydrocodone was dated 07/2/2013. There is no documentation on the pain relief (in terms of pain scale) and functional improvement (in terms of specific activities of daily living) that the patient can perform attributed to the use of opioids. MTUS Guidelines require clear and concise documentation for ongoing management. Therefore, the request for Hydrocodone 2.5/325 (Norco), 1 Tablet By Mouth Up To 3 X Daily As Needed For Pain Control #60, Plus One Refill is not medically necessary.