

<b>Case Number:</b>	CM14-0018706		
<b>Date Assigned:</b>	04/18/2014	<b>Date of Injury:</b>	06/03/2002
<b>Decision Date:</b>	07/02/2014	<b>UR Denial Date:</b>	01/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2014

### 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 Anesthesiology & Pain Medicine and is licensed to practice in Florida. 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 49-year-old female who reported an injury on 06/03/2002. The mechanism of injury was not provided for review. The injured worker ultimately underwent cervical fusion in 2007. The injured worker's chronic pain was managed with medications. The injured worker was monitored with aberrant behavior with urine drug screens. The injured worker's medications included Norco, Vicoprofen 7.5/200 mg 6 per day, Avinza 90 degrees 1 daily, Soma 350 mg 3 daily, and Topamax 25 mg 1 daily. The injured worker reported no significant side effects related to medication usage. The injured worker was evaluated on 12/11/2013. It was noted that the injured worker had 7/10 that was reduced to 4/10 pain with medication usage. It was also documented the injured worker had been evaluated in 09/2013 with a urine drug screen and a CURES report that were consistent with the prescribed medication schedule. The injured worker's diagnoses included chronic neck pain, chronic bilateral hip pain, chronic left scapular/shoulder pain, chronic compensatory muscle spasms, scapulothoracic crepitus syndrome, syringomyelia, and bilateral trochanteric bursitis. The injured worker's treatment plan included continuation of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**HYDROCODONE/IBU 7.5/200MG, #150:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, ON-GOING MANAGEMENT Page(s): 78.

**Decision rationale:** The requested Hydrocodone/Ibuprofen 7.5/200 mg #180 is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended duration of time. California Medical Treatment Utilization Schedule recommends ongoing use of medications be supported by documented functional benefit, evidence of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does provide evidence of pain relief. The injured worker has a reduction in pain from 7/10 to 8/10 to a 4/10 with medication usage. However, there is no documentation of significant functional benefit as result of medication usage. It is documented that the injured worker does not have any significant side effects due to medication usage and is monitored for aberrant behavior. However, in the absence of significant functional benefit, continued use would not be supported. Also, the request as it is submitted does not specifically identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Hydrocodone/Ibuprofen 7.5/200 mg #180 is not medically necessary or appropriate.