

<b>Case Number:</b>	CM14-0116809		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	04/19/2010
<b>Decision Date:</b>	09/15/2014	<b>UR Denial Date:</b>	06/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/25/2014

### 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 Physical Medicine & Rehab, has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma and Texas. 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 50-year-old male who reported an injury on 04/19/2010. The mechanism of injury was not provided. On 06/20/2014 the injured worker presented with hip pain. Upon examination there was tenderness to palpation noted over the paraspinal muscles overlying the facet joints and SI joints bilaterally. There was limited range of motion to the bilateral lower extremities. There was crepitus noted within the knee joints bilaterally, and normal motor strength and muscle tone. Current medications included Viagra, hydrocodone, acetaminophen, and Cymbalta. Diagnoses were osteoarthritis of the knee, degeneration of the lumbar intervertebral discs, chronic pain syndrome, hip pain and drug induced impotence. The provider recommended hydrocodone/acetaminophen 10/325 mg. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone/Acetaminophen 10/325mg #75 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, for chronic pain.

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

**Decision rationale:** The request for hydrocodone/acetaminophen 10/325 mg with a quantity of 75 and 3 refills is not medically necessary. The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of evidence of an objective assessment of the injured worker's pain level, functional status, evaluation for risk aberrant drug abuse behavior and side effects. The injured worker has been prescribed hydrocodone/acetaminophen since at least 06/2014. The efficacy of the medication has not been provided. Additionally, the provider's request does not indicate the frequency of the medication in the request as submitted. As such, the request is not medically necessary.