

<b>Case Number:</b>	CM14-0173068		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	02/26/2007
<b>Decision Date:</b>	12/11/2014	<b>UR Denial Date:</b>	10/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2014

### 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 Massachusetts, New Hampshire and New York. 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 53 year old male who reported an injury on 02/26/2007. The mechanism of injury was sanding an airplane. His diagnoses include lumbar degenerative disease, lumbosacral or thoracic neuritis or radiculitis, spinal stenosis in the lumbar region, lumbar facet syndrome and lumbar radiculopathy. His past treatments were noted to include home exercise program, TENS unit, work modification and medication. During the evaluation dated 09/27/2014 the injured worker complained of intermittent low back pain that sometimes radiates to the lower extremities, more to the left than the right. He rated his pain a 5/10 and stated the medication help with 50% of the pain control and assist with his activities of daily living. There was no aberrant behavior or side effects noted from the current medication. The physical examination revealed positive diffused tenderness to palpation and decreased range of motion in the lumbar spine. His medication was noted to include Tramadol/APAP 37.5/325mg, omeprazole 20mg, Lidopro ointment and Gabapentin 100mg. The treatment plan was to continue home exercise program, TENS unit and medication. The rationale for Ultracet 37.5/325mg was not provided. The Request for Authorization form was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultracet 37.5/325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, On-going Management Page(s): 78.

**Decision rationale:** The California MTUS Guidelines state that the ongoing management of opioid use should include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects.. The injured worker was noted to have 50% pain relief with use of his medications, as well as increased activities of daily living. The documentation also indicated he had no aberrant behavior or side effects noted from the current medication. However, there was no evidence of consistent results on a urine drug screen within the last year to verify appropriate medication use. Additionally, the frequency was not provided. As such, the request is not medically necessary.