

<b>Case Number:</b>	CM14-0023748		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	02/10/2011
<b>Decision Date:</b>	07/15/2014	<b>UR Denial Date:</b>	02/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/25/2014

### 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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in 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 59-year-old male who reported an injury February 10, 2011. The mechanism of injury was not provided within the medical records. The clinical note dated February 11, 2014 indicated the injured worker reported pain in the shoulders bilaterally, neck, triceps region, and the back of the arms. He described his pain as sharp, deep, and burning. On physical exam, the cervical spine was stiff. The injured worker's upper extremities were stiff with crepitus, more right than left. The injured worker's prior treatments have included medication management. The injured worker's medication regimen included Fentanyl patch, hydrocodone, Mobic, Pantoprazole and methadone. The provider submitted a request for hydrocodone. A request for authorization was not submitted for review to include the date the treatment was requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**HYDROCODONE 10/325MG #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain.

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

**Decision rationale:** The California Chronic Pain Medical Treatment Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of significant evidence of an objective assessment of the injured worker's pain level, functional status, evaluation of risk for aberrant drug use, behaviors, and side effects. Furthermore, the request does not indicate a frequency for the medication. Therefore, the request for hydrocodone 10/325 mg 90 is not medically necessary.