

<b>Case Number:</b>	CM14-0028982		
<b>Date Assigned:</b>	06/16/2014	<b>Date of Injury:</b>	07/25/2005
<b>Decision Date:</b>	08/25/2014	<b>UR Denial Date:</b>	02/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2014

### 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 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 injured worker is a 44-year-old male who reported injury 07/25/2005. The mechanism of injury was the injured worker fell off a lawn mower that would not stop. The injured worker underwent a lumbar laminectomy and discectomy on 07/25/2006. Other treatments included physical therapy, epidural steroid injections, and medications. The injured worker was noted to be utilizing opiates as of at least 02/2013. The documentation of 01/27/2014 revealed the injured worker had subjective complaints of low back pain with his right leg falling asleep sometimes, so that the injured worker could not feel it. The injured worker had objective findings of decreased flexion at the waist to 50 degrees, a positive supine straight leg raise test, and weakness of the extensor hallucis longus grade 4/5. The diagnosis included lumbar disc disorder without myelopathy. The 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 10MG ACETAMINOPHEN 325MG #60 TIMES 1 REFILL:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91. Decision based on Non-MTUS Citation Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain On-going Management Page(s): 60, 78.

**Decision rationale:** The California MTUS Guidelines recommend Opiates for the treatment of chronic pain. There should be documentation of objective functional benefit and objective pain relief. There should be documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for at least 11 months. There was lack of documentation of objective functional benefit, and objective decrease in pain and documentation the injured worker is being monitored for aberrant drug behavior and side effects. Additionally, the request as submitted failed to indicate the frequency for the requested medication. The clinical documentation failed to indicate a necessity for 1 refill without re-evaluation. Given the above, the request for Hydrocodone 10 mg/Acetaminophen 325 mg #60 is not medically necessary.