

<b>Case Number:</b>	CM14-0050035		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	10/17/2008
<b>Decision Date:</b>	09/15/2014	<b>UR Denial Date:</b>	03/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/17/2014

### 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 and Rehabilitation and is licensed to practice in Nevada. 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 52-year-old gentleman who was reportedly injured on October 17, 2008. The mechanism of injury is not listed in these records reviewed. The most recent progress note dated January 27, 2014, indicates that there are ongoing complaints of upper back pain, lower back pain, and bilateral lower extremity pain. Current medications were stated to include gabapentin, Norco, Flexeril, Ducoprene, Lidopro and Prilosec. The physical examination demonstrated ambulation with the assistance of a cane. There was tenderness of the lumbar paraspinal muscles with spasms. Decreased lumbar spine range of motion was noted in all planes. Neurological examination revealed decreased sensation at the bilateral L4, L5 and S1 dermatomes. There was a positive straight leg raise test. Diagnostic imaging studies were not reviewed during this visit. Previous treatment includes a lumbar spine micro decompression and epidural steroid injections. A request was made for hydrocodone and was not certified in the pre-authorization process on March 17, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone 10/325Mg #180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS CRITERIA FOR USE 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 74-78, 88, 91 of 127.

**Decision rationale:** Hydrocodone is a short acting opiate indicated for the management of moderate to severe breakthrough pain. The California Medical Treatment Utilization Schedule guidelines support short-acting opiates at the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured employee has chronic pain; however, there is no objective clinical documentation of improvement in their pain or function with the current regimen. As such, this request for hydrocodone is not medically necessary.