

<b>Case Number:</b>	CM14-0062429		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	01/15/2010
<b>Decision Date:</b>	09/15/2014	<b>UR Denial Date:</b>	04/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/05/2014

### 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 Neurological Surgery and is licensed to practice in 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 records presented for review indicate that this 49 year-old individual was reportedly injured on 1/15/2010. The mechanism of injury is not listed. The most recent progress note, dated 4/4/2014, indicates that there are ongoing complaints of low back and bilateral shoulder pain. The physical examination demonstrated lumbar spine: positive tenderness to palpation at the lumbosacral junction. Range of motion is decreased. Sensation intact to light touch at the bilateral lower extremities. Deep tendon reflexes 2+ lower extremities. Muscle strength 5/5. Right shoulder: positive tenderness to palpation over the rotator cuff muscles. Decreased range of motion. Positive impingement sign. No reason diagnostic studies are available for review. Previous treatment includes medications, and conservative treatment. A request had been made for hydrocodone 10/325 mg #120 and was not certified in the pre-authorization process on 4/21/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone/APAP 10-325mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78,88,91 of 127.

**Decision rationale:** As noted in the MTUS this is for the short-term management of moderate to severe breakthrough pain. Furthermore, as outlined in the MTUS the treatment plan parameters outlined in the MTUS for chronic opioid use require noting if the diagnosis has changed, other medications being employed, if any attempt has been made to establish the efficacy of the medications and documentation of functional improvement. Furthermore, adverse effects have to be addressed. None of these parameters to continue this medication chronically have been measured. Therefore, the medical necessity is not established.