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| <b>Case Number:</b>   | CM14-0067794 |                              |            |
| <b>Date Assigned:</b> | 06/27/2014   | <b>Date of Injury:</b>       | 07/09/2001 |
| <b>Decision Date:</b> | 08/18/2014   | <b>UR Denial Date:</b>       | 03/20/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 04/01/2014 |

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. 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 72-year-old female who reported an injury on 07/09/2001. The mechanism of injury was not provided. On 03/11/2014, the injured worker presented with radicular low back pain. Upon examination, the injured worker ambulated with a slow, steady gait and utilized a 4-point cane for ambulation assistance. Diagnoses were medication management, chronic lumbar radiculitis left, and history of posterior lumbar fusion at L4-5 level, failed back syndrome, and myofascial pain. Previous medications included; hydrocodone/acetaminophen, and ibuprofen. The provider recommended hydrocodone/acetaminophen 10/325 mg with a quantity of 120. The provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone/Acetaminophen 10/325mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid, Criteria for use Page(s): 78.

**Decision rationale:** The California MTUS Guidelines recommend providing ongoing education of both the benefits and limitation of opioid treatment. The guidelines recommend the lowest possible dose should be prescribed to improve pain and function. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The pain assessment should include current pain; least reported pain over the period since the last assessment, average pain, and intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Satisfactory response to treatment may be indicated by the injured worker's decrease in pain, increased level of function, or improved quality of life. The provided medical documentation lacked evidence that the injured worker's failure to respond to non-opioid analgesic. Additionally, the injured worker has been prescribed opioids chronically for years, and there is no efficacy of the medication documented, to include an adequate pain assessment of the injured worker was not included. Such as, Hydrocodone/Acetaminophen 10/325mg #120 is not medically necessary.