

<b>Case Number:</b>	CM14-0075045		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	05/31/2012
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	05/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/22/2014

### 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, has a subspecialty in Interventional Spine 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 patient is a 53-years old female with an injury date on 05/31/2012. Based on the 04/28/2014 progress report provided by [REDACTED] the diagnoses are: 1. Thoracic or Lumbosacral Neuritis or Radiculitis Not Otherwise Specified. 2. Sprains and Strains of Lumbar Region. According to this report, the patient complains of lower back pain and left hip pain. Patient rates the pain as a 7/10. She states that medications are helping and shows no evidence of developing medication dependency. The patient's current medications are Naproxen, Methoderm, and Hydrocodone/Acetaminophen. The lumbar range of motion is restricted with pain. On the sensory examination, light touch sensation is decreased over L5, S1 dermatomes on the right side. There were no other significant findings noted on this report. [REDACTED] is requesting Hydrocodone/Acetaminophen 10/325 1-2 every 6 hours as needed. The utilization review denied the request on 05/19/2012. [REDACTED] is the requesting provider, and he provided treatment reports from 06/12/2013 to 06/26/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone/Acetaminophen 10/325 1-2 q6 hours prn:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
CRITERIA FOR USE OF OPIOIDS Page(s): 88, 89.

**Decision rationale:** For chronic opiate use, MTUS Guidelines pages 88 and 89 require functioning documentation using a numerical scale or validated instrument at least once every six months. Documentation of the 4 A's (analgesia, ADLs, adverse side effects, adverse behavior) is required. Furthermore, MTUS guidelines, under outcome measure recommend documentation of chronic pain, average pain, least pain, the time it takes for medication to work, duration of pain relief with medication, etc. In this case, the physician only provides pain scale without providing before/after to show medication analgesia. The physician only mentions generic statements without going into the specifics regarding the patient's ADL's and what the use of medication has done to improve function. Documentation of the 4 A's, as required by MTUS were also not provided. Given the lack of sufficient documentation demonstrating efficacy for chronic opiate use, the patient should slowly be weaned as outlined in MTUS Guidelines. Therefore, Hydrocodone/Acetaminophen 10/325 1-2 every 6 hours as needed is not medically necessary.