

<b>Case Number:</b>	CM14-0080002		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	04/16/1995
<b>Decision Date:</b>	08/25/2014	<b>UR Denial Date:</b>	05/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/30/2014

### 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 Management, 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 60-year-old male with date of injury of 04/16/1995. The listed diagnosis on 03/18/2014 is lumbar degenerative disk disease. According to this report, the patient complaints of persistent back pain. The back pain is characterized as a dull, achy, and stabbing. These symptoms are aggravated by exertion including twisting, turning, and bending. His current list of medications includes Vicodin, Ibuprofen 800 mg, and Hydrochlorothiazide. The physical exam shows painful limited lumbar extension causing pain, right greater than the left. Extension is limited to 50% of normal. Flexion is 70% of normal. Right lateral side bend increases right lower back pain. There is tenderness to palpation present over the lumbar facets. Straight leg raise is negative. Motor sensory examination is normal. The utilization review denied the request on 05/06/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Medication Hydrocodone Bitartrate/Acetaminophen 5/500mg # 90 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 78 of 127.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines The Expert Reviewer based his/her decision on the MTUS page 78 Page(s): 78.

**Decision rationale:** This patient presents with chronic low back pain. The treating provider is requesting narcotic Hydrocodone Bitartrate/Acetaminophen 5/500 mg. For chronic opiate use, the MTUS Chronic Pain Guidelines requires specific documentations regarding pain and function. Page 78 of the MTUS Chronic Pain Guidelines requires pain assessment that requires current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioids; how long it takes for pain relief; how long pain relief last. Furthermore, the 4As for ongoing monitoring are required which includes: analgesia, activities of daily living (ADLs), adverse side effects, and aberrant drug seeking behavior. The records show that the patient started taking Vicodin on 03/19/2013. The treating provider does not document medication efficacy including before and after analgesia. Specifics regarding ADLs to denote significant improvement or any mention of quality life changes. There is no discussion regarding pain assessments using a numerical scale. No mention of adverse side effects and aberrant drug seeking behavior such as a urine drug screen. Therefore, the request for Hydrocodone Bitartrate/Acetaminophen 5/500mg #90 is not considered medically necessary and appropriate.