

<b>Case Number:</b>	CM13-0027666		
<b>Date Assigned:</b>	11/22/2013	<b>Date of Injury:</b>	10/12/2007
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	08/29/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2013

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
State(s) of Licensure: California, Indiana, New York  
Certification(s)/Specialty: Internal Medicine

### 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 sustained a work related injury on October 12, 2007, from a fall onto the left side with the entire body bruised and jolted during the fall. A lumbar MRI dated January 18, 2008, was noted to show a large disc protrusion at the level of L5-S1 with minimal disc bulging at the level of L4-L5. A MRI of the lumbosacral spine dated June 19, 2013, was noted to show a 4mm disc protrusion at L4-L5 causing a mild right lateral recess stenosis, mild bilateral L5-S1 neuroforaminal stenosis, posterior displacement and distortion of the right S1 nerve root, elevation and impingement of the L5 nerve roots in the L5-S1 neuroforamen bilaterally. On June 17, 2013, an electrodiagnostic study of the extremities was noted show a normal electromyography (EMG) of the upper and lower extremities with the nerve conduction study (NCS) consistent with mild left peroneal motor neuropathy at the ankle. A June 25, 2013 ultrasound of the bilateral buttock region was noted to show left piriformis musculature edema, fibrosis, and microtearing with mild compromise to the sciatic nerve, and a right normal piriformis region. An ultrasound of the bilateral shoulders dated June 25, 2013, was noted to show normal bilateral shoulders. A copy of the June 2013 electrodiagnostic studies was not included in the documentation provided. The injured worker's previous conservative treatments were noted to have included acupuncture, physical therapy, chiropractic care, aquatic therapy, piriformis injection, bracing, and oral medications. An orthopedic evaluation as part of an Agreed Medical Examination dated June 13, 2013, noted the injured worker with intermittent pain in the neck radiating to bilateral shoulders/arms down to the hands, intermittent moderate pain in the shoulders radiating to the hands and fingers with numbness and tingling in the

shoulders/arms, intermittent hand/wrist pain, moderate sharp pain in the lower back radiating to the buttocks and legs, intermittent bilateral hip pain radiating to the legs, intermittent slight to moderate pain in the left knee with clicking, popping, and locking, frequent headaches, difficulty sleeping, anxiety, depression, and constipation due to the medications. Physical examination was noted to show pain with terminal range of motion and resisted abduction of the left shoulder with myofascial tenderness to palpation of the left trapezius, and lumbar spine muscle guarding, pain towards terminal range of motion, paraspinal musculature and spinous process tenderness to palpation, and tenderness to palpation of the piriformis/gluteus group on the left. The Physician's impressions were noted as cervical spine with no current clinical evidence of abnormality, left shoulder impingement; rule out rotator cuff tear, right and left wrist/hand no current clinical evidence of injury, chronic low back pain; rule out herniated disc causing intermittent radiculopathy into the left lower extremity, mid back, left hip, and left knee with no current clinical evidence of abnormalities, and complaints of psychological problems as well as difficulty sleeping. The Primary Treating Physician has requested authorization for Vicodin 5/500mg every twelve hours #60 and Lyrica 75mg twice a day #60. On August 29, 2013, Utilization Review evaluated the request for Vicodin 5/500mg every twelve hours #60 and Lyrica 75mg twice a day #60, citing the MTUS Chronic Pain Medical Treatment Guidelines. The UR Physician noted the Lyrica 75mg twice a day #60 was certified. The UR Physician noted the documentation for review was handwritten and extremely difficult to make out, however, it appeared that the urine drug screen performed on June 7, 2013 was noted to be negative for the prescribed hydrocodone, thus indicating possible diversion/aberrant behavior. The UR Physician noted that there was no legible documentation of significant functional/vocational benefit with the use of opioids to support ongoing use. The request for Vicodin 5/500mg every twelve hours #60 was noted as not approved. The decision was subsequently appealed to Independent Medical Review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**VICODIN 5/500MG EVERY 12 HOURS #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opiates Page(s): 74-96.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Vicodin 5/500 mg one tablet every 12 hours #60 is not medically necessary. Ongoing, chronic opiate use requires an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. A detailed pain assessment should accompany ongoing opiate use. Satisfactory response to treatment may be indicated by the patient's decreased pain, increase level of function or improved quality of life. The lowest possible dose should be prescribed to improve pain and function. In this case, the injured workers working diagnoses are cervical radiculopathy, and myofascial pain syndrome. The remaining diagnoses were illegible. Subjective and objective complaints were illegible. Viking

and was prescribed as far back as February 19, 2013. It is unclear whether this is a new prescription or refill. There were no risk assessments in the medical record. There were no pain assessment in the medical record. There was no documentation indicating objective functional improvement with Vicodin. A urine drug toxicology screen from June 7 of 2013 while the injured worker was taking Vicodin was negative for Vicodin (and inconsistent UDS). The treating physician did not address the urine drug inconsistency in the medical record. The treatment plan was illegible. Consequently, absent clinical documentation to support the ongoing use of Vicodin with objective functional improvement and an inconsistent urine drug's toxicology screen, Vicodin 5/500 mg one tablet every 12 hours as take 60 is not medically necessary.