

<b>Case Number:</b>	CM14-0191151		
<b>Date Assigned:</b>	11/25/2014	<b>Date of Injury:</b>	03/25/1998
<b>Decision Date:</b>	01/09/2015	<b>UR Denial Date:</b>	11/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/17/2014

### 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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 59 year old person with date of injury 3/25/98. Medical records indicate the patient is undergoing treatment for lumbar radiculopathy. Subjective complaints are left shoulder pain, feeling a "catch" in the left shoulder with movement, pain rated 7/10 at worst increasing with positioning and loading. Objective findings are negative straight leg raise, motion limited in abduction, good strength; left shoulder range of motion flexion 128 degrees, abduction 150 degrees; right shoulder range of motion (ROM) flexion 152 degrees, abduction 167 degrees. Treatment has included physical therapy, TENS unit, gym membership, exercise kit, chiropractic treatment, home exercise program, interferential unit, moist heat, psychotherapy, lumbar epidural steroid injection, Theramine, Hydrocodone with Theramine co-pack and Myotool. The utilization review determination was rendered on 11/10/14 recommending non-certification of Hydrocodone 10/325mg 60.00.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone 10/325mg 60.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-going management Page(s): 80-81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone, Opioids Page(s): 51, 74-95.

**Decision rationale:** Official Disability Guidelines (ODG) does not recommend the use of opioids for low back pain "except for short use for severe cases, not to exceed 2 weeks." California MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; 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 patient's decreased pain, increased level of function, or improved quality of life." The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. Additionally, medical documents indicate that the patient has been on an opioid in excess of the recommended 2-week limit. The treating physician does not provide sufficient information to substantiate the need for continued opioid medication. Prior utilization reviews have noted the need for tapering and weaning. As such, Hydrocodone 10/325mg 60.00 is not medically necessary.