

<b>Case Number:</b>	CM14-0198926		
<b>Date Assigned:</b>	12/09/2014	<b>Date of Injury:</b>	08/08/2012
<b>Decision Date:</b>	01/22/2015	<b>UR Denial Date:</b>	11/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/26/2014

### 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 Internal Medicine 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 injured worker (IW) is a 39-year-old man with a date of injury of August 8, 2012. The mechanism of injury occurred when picture frames fell off a top shelf and hit him on the head. He believed he was knocked unconscious. He was taken to the emergency room and was hospitalized for 5 days. The current diagnoses are persistent headache attributed to mild traumatic injury to the head, chronic migraine; persistent postconcussive syndrome following mild traumatic brain injury; major depressive disorder, single episode, severe without psychosis; history of seizure three times in 2012 following his injury; and blurred vision. Pursuant to the progress noted dated October 7, 2014, the IW complains of low back pain. He is also having daily headaches of moderate to severe intensity and functional impact. Objectively, the IW has a clear sensorium, and his affect was normal. Gait is normal. Current medications include Divalproex Sodium ER 1000mg at bedtime, Duloxetine 30mg at bedtime, and Hydrocodone/APAP 10/325mg TID as needed. Documentation indicated that the IW has been taking Vicodin since at least July 15, 2010. There were no detailed pain assessments or documentation of objective functional improvement associated with the long-term use of Hydrocodone/APAP. The current request is for Hydrocodone/APAP #42 for weaning.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone w/APAP #84 for weaning:** Upheld

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

**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, Hydrocodone/APAP #84 for weaning 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 chronic opiate use. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function or improved quality of life. The lowest possible dose should be prescribed to improve pain and function. Chronic Pain Guidelines recommend ongoing opiate use is justified by documentation of objective pain relief and increased ability to perform activities of daily living in addition to side effects and aberrant behavior documentation. In this case, a progressive dated November 3, 2014 indicates working diagnoses are: persistent headache attributed to mild traumatic injury to the head (chronic migraine); persistent post concussive syndrome following mild dramatic brain injury on August 8, 2012; major depressive disorder, single episode, severe without psychosis; history of seizure times three in 2012 following his August 8, 2012 injury; and blurred vision. The documentation reflects the injured worker was taking Vicodin as far back as July 15, 2010. As of December 1, 2014, the injured worker was still actively taking hydrocodone/APAP 10/325 TID PRN #84. A CURES report was checked and consistent with the treatment history. A urine drug screen was checked on March 27, 2014 and was consistent with his prescriptions. The injured worker signed the treatment agreement for the controlled substances. The treating physician "recommended" the injured worker reduce his dosage by 50%. There is no indication the treating physician reduced the quantity of his hydrocodone any further. There is no documentation of objective pain relief or evidence of objective functional improvement. There are no detailed pain assessments in the medical record. Consequently, absent the appropriate documentation with evidence of objective functional improvement, hydrocodone /APAP 10/325mg is not medically necessary.