

<b>Case Number:</b>	CM14-0200003		
<b>Date Assigned:</b>	12/10/2014	<b>Date of Injury:</b>	07/18/2002
<b>Decision Date:</b>	01/26/2015	<b>UR Denial Date:</b>	11/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/01/2014

### 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 New York. 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 claimant is a 53 years old female who sustained an industrial injury on 07/18/2002. The mechanism of injury occurred when she caught her right foot in plastic and she fell injuring her right knee. Her diagnosis is right knee pain. She is status post arthroscopic surgery. She continues to complain of right knee pain. On physical exam she has right knee pain which increases with squatting. There is decreased range of motion with crepitus. Treatment in addition to surgery has included medical therapy with Hydrocodone/Acetaminophen. The treating provider has requested Hydrocodone/Acetaminophen 5/325mg # 90.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone 5/325 #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80, 81, 92.

**Decision rationale:** There is no documentation provided necessitating the continued use of Hydrocodone/APAP 10/325 for the claimant's chronic pain condition. The literature indicates that in chronic pain analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs.

Opioid therapy for pain control should not exceed a period of 2 weeks and should be reserved for moderate to severe pain. The failure to respond to a time limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no evidence indicating significant trials of non-opiate medication used for the treatment of chronic pain have been tried prior to the requested continued opiate therapy. The claimant might benefit from a multidisciplinary approach to her chronic pain condition. Medical necessity for the requested item has not been established. The requested treatment is not medically necessary.