MAXIMUS Federal Services

| Case Number: | CM15-0135189 | | |
|---|---|---|---|
| Date Assigned: | 07/23/2015 | Date of Injury: | 04/24/2005 |
| Decision Date: | 08/19/2015 | UR Denial Date: | 06/26/2015 |
| Priority: | Standard | Application Received: | 07/13/2015 |

## 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: 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 is a 54-year-old female with an industrial injury dated 04/25/2005. Her diagnoses included chronic pain, disc displacement of the cervical spine, cervical radiculopathy and right shoulder pain. Comorbid diagnosis was hypertension. Prior treatment included cervical epidural steroid injection right cervical 5-7 and medication. She presents on 06/11/2015 with complaints of low back pain radiating down the right lower extremity. The pain was accompanied by numbness and tingling. The pain was rated as 2/10 in intensity on average with medications since last visit. Without the medications, it was rated 9/10 in intensity on average without medications. The pain was reported unchanged since her last visit. She reports ongoing limitations in activities of daily living. Physical examination of the cervical spine noted tenderness in the areas of cervical 5-7. There was tenderness upon palpation of the right paravertebral cervical 5-7 area. Myofascial trigger points with twitch response were noted in the right trapezius muscle. Range of motion was moderately limited due to pain, which was significantly increased with flexion, extension and rotation. Lumbar spine examination noted straight leg raise was positive in the seated position on the right. Exam of the right shoulder noted tenderness in the joint with decreased range of motion due to pain. Grip strength was decreased on the right. Work status - currently not working. Functional improvement because of treatment is documented as 50% in areas of cooking, dressing, driving, standing in line, talking on the phone and washing dishes. She reports her quality of life has been improved because of the treatment. Treatment plan included medications and follow up. The provider documents the injured worker is demonstrating an improvement in level of function, not experiencing side

effects, complying with pain management agreement and behavior and mood were appropriate. The provider documents the injured worker is monitored with urinary drug testing and CURES and has been compliant. The requested treatment for Gabapentin 300 mg # 30 and outpatient follow up office visit was authorized. The treatment request for review is Hydrocodone 10/325 mg #60.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone 10/325 mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

**Decision rationale:** According to ODG and MTUS, Hydrocodone is a short-acting opioid analgesic. Opioid drugs are available in various dosage forms and strengths. These medications are generally classified according to potency and duration of dosage. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. In addition, guidelines necessitate documentation that the prescriptions are from a single practitioner and taken as directed. This was not documented in the records. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The request for retrospective Hydrocodone is not medically necessary.