

<b>Case Number:</b>	CM15-0147921		
<b>Date Assigned:</b>	08/11/2015	<b>Date of Injury:</b>	04/07/2006
<b>Decision Date:</b>	09/22/2015	<b>UR Denial Date:</b>	07/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 53-year-old female, with a reported date of injury of 04-07-2006. The mechanism of injury was not indicated in the medical records provided for review. The injured worker's symptoms at the time of the injury were not indicated. The diagnoses include low back pain, sciatica, displacement of lumbar intervertebral disc, lumbar disc with radiculitis, and degeneration of lumbar disc. Treatments and evaluation to date have included oral medications and psychological counseling. The diagnostic study reports were not included. The medical report dated 07-10-2015 indicates that the injured worker had a history of right-sided low back and right extremity pain. She stated that he pain had increased since the last visit. The injured worker noted low back pain with radiation down the posterolateral aspect of the right leg that stopped at the knee. She denied having any numbness or tingling; however, she admitted have weakness of the left leg. The injured worker's current pain level was rated 3 out of 10. An MRI of the lumbar spine dated 05-04-2012 showed minimal disc desiccation without narrowing throughout the lumbar spine; there were no disc bulges or protrusions; and there were no significant incidental findings. It was noted that an MRI of the lumbar spine in 2009 showed disc bulges and facet arthropathy with neuroforaminal compression. The injured worker had pain that was axial and radicular in nature along the right lower extremity. It was noted that she needed treatments with stabilization, exercise, and medications. It was also noted that Gabapentin caused side effects and the injured worker stopped taking it. The injured worker felt very depressed. The physical examination showed no acute distress; a non-antalgic gait; and the ability to sit for 15 minutes without any limitations or evidence of pain; a normal affect. It was

noted that an electrodiagnostic study performed in 07-2009 showed acute lumbar radiculopathy at L3 and L5. The injured worker's work and disability status was not indicated. The treatment plan included the refill of Hydrocodone-Acetaminophen 5-325mg, #90, one tablet three times a day as needed. The medical report dated 05-26-2015 indicates that the injured worker stated that her right-sided low back and right extremity pain had increased since the last visit. Her current plan level was rated 3 out of 10. Her pain rating was noted as 7 out of 10 under the objective findings. The objective findings included a non-antalgic gait, no acute distress, and the ability to sit for 15 minutes without any limitations or evidence of pain. The injured worker's work and disability status was not indicated. The treating physician 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-Acetaminophen 5-325mg #90, one tablet three times daily as needed:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Section, Weaning of Medications Section Page(s): 74-95, 124.

**Decision rationale:** The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. The injured worker has been taking Hydrocodone-Acetaminophen for an extended period without objective documentation of functional improvement or significant decrease in pain. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment. The request for Hydrocodone-Acetaminophen 5-325mg #90, one tablet three times daily as needed is determined to not be medically necessary.