

<b>Case Number:</b>	CM15-0163428		
<b>Date Assigned:</b>	08/31/2015	<b>Date of Injury:</b>	02/08/2008
<b>Decision Date:</b>	09/30/2015	<b>UR Denial Date:</b>	08/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/20/2015

### 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: Physical Medicine & Rehabilitation

### 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 62 year old female who sustained an industrial-work injury on 2/8/08. She reported an initial complaint of left knee and back pain with lower extremity symptoms. The injured worker was diagnosed as having lumbar spondylosis, bilateral knee osteoarthritis, patellar tendinitis, left knee. Treatment to date includes medication, diagnostics, injection, home exercise, physical therapy, and activity modification. Currently, the injured worker complained of left knee pain ranging 5-8 out of 10, right knee, low back, and right shoulder. Per the primary physician's report (PR-2) on 7-11-15, exam notes tenderness with paraspinal spasm, flexion of 0-50 degrees, extension 0-20 degrees, lateral left-right 0-20 degrees, lower extremity neurological evaluation has diminished sensation at left S1 dermatomal distribution, 5- out of 5 strength, distal pulses 2+ and symmetrical, left knee range of motion 0-120. Right knee has painful patellofemoral crepitation. The requested treatments include Hydrocodone 60mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone 60mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 94-95.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, page(s) 74-96.

**Decision rationale:** Pain symptoms and clinical findings remain unchanged for this chronic injury. Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or improved functional status. There is no evidence presented of random drug testing results or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain for this chronic injury. In addition, submitted reports have not adequately demonstrated the specific indication to support for chronic opioid use without acute flare-up, new injuries, or progressive clinical deficits to support for chronic opioids outside recommendations of the guidelines. The Hydrocodone 60mg #60 is not medically necessary.