

<b>Case Number:</b>	CM15-0049757		
<b>Date Assigned:</b>	03/23/2015	<b>Date of Injury:</b>	10/04/2002
<b>Decision Date:</b>	05/06/2015	<b>UR Denial Date:</b>	03/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/16/2015

### 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 Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 50 year old male, who sustained an industrial injury on 10/04/2002. Initial complaints reported included neck pain, low back pain, bilateral shoulder pain, and left leg pain. The injured worker was diagnosed as having closed head injury. Treatment to date has included conservative care, medications, left shoulder surgery, epidural steroid injections, conservative therapies, and psychological/psychiatric therapy. Currently, the injured worker complains of severe pain to neck, head and both shoulders without medications, irritability and angry outburst. Current diagnoses include angry outburst followed by agitation, withdrawal from medications, cervical disc herniation, chronic pain neck, and shoulders. The treatment plan consisted of medications (hydrocodone, Flexeril and Zoloft) and follow-up.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone 10/300mg #240 with 1 refill:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-79.

**Decision rationale:** According to MTUS guidelines, Hydrocodone is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. There is no clear justification for the need to continue the use of Hydrocodone. The patient was previously treated with Hydrocodone without any evidence of pain and functional improvement. There is no documentation of compliance of the patient with his medications. Therefore, the prescription of Hydrocodone 10/300mg #240 with 1 refill is not medically necessary.