

<b>Case Number:</b>	CM15-0055420		
<b>Date Assigned:</b>	03/30/2015	<b>Date of Injury:</b>	04/01/2011
<b>Decision Date:</b>	05/07/2015	<b>UR Denial Date:</b>	02/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/23/2015

### 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: Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 45 year old female, who sustained an industrial injury on April 1, 2011. She has reported neck pain and back pain. Diagnoses have included Thoracic spine degenerative disc disease, myofascial pain, lumbar spine radiculopathy, disorder of the rotator cuff, cervical spine spondylosis with radiculopathy, trochanter bursitis, knee pain and chronic pain syndrome. Treatment to date has included medications, transforaminal epidural steroid injection, back surgery and shoulder surgery. The MRI report noted T7-T8 disc bulge. On 8/6/2014, it was noted that the IW was utilizing only OTC pain medications. A progress note dated December 16, 2014 indicates a chief complaint of neck pain and thoracic spine pain. The treating physician documented a plan of care that included medications and a thoracic spine epidural. The medications listed are Hydrocodone/APAP and Lunesta.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone/Acetaminophen 10/325mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 42-43, 74-96, 124. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Opioids.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that opioids can be utilized for the short term treatment of exacerbation of musculoskeletal pain when standard treatment with NSAIDs and PT have failed. The chronic use of opioids is associated with the development of tolerance, dependency, addiction, sedation, opioid induced hyperalgesia and adverse interaction with sedative medications. The records did not show documentation of guidelines required compliant monitoring of serial UDS, absence of aberrant behavior and functional restoration. Hydrocodone/APAP 10/325mg # 120 is not medically necessary.