

<b>Case Number:</b>	CM15-0080047		
<b>Date Assigned:</b>	05/01/2015	<b>Date of Injury:</b>	04/28/2003
<b>Decision Date:</b>	06/02/2015	<b>UR Denial Date:</b>	04/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/27/2015

### 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 35 year old male patient who sustained an industrial injury on 04/28/2003. A primary treating office visit dated 09/26/2014 reported the patient with a chief complaint of degeneration of thoracic, cervical and lumbar intervertebral disc, shoulder joint pain and disorder of bursa of the shoulder region. The subjective complaint was chronic left shoulder pain accompanied with stiffness, spasm and weakness. In addition, he states having numbness in the left upper extremity. He is currently working and is participating in exercise and stretching. He reports taking Etodolac with a noted 60 % decrease in pain which allows more function. He also takes Hydrocodone/APAP. The following diagnoses are applied: degeneration of cervical, thoracic, and lumbar intervertebral disc; disorder of bursa of shoulder, and shoulder joint pain. The plan of care involved: continuing with current medications. A more recent follow up visit dated 04/09/2015 reported no change in chief complaints. No change in subjective complaint of pain. The Pain Contract was signed on 12/12/2014. The CURES and UDS reports are consistent with prescribed hydrocodone.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone-Acetaminophen 10/325 mg #180 with 2 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**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 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, opioid induced hyperalgesia, sedation and adverse interaction with other medications. The records did not show the patient failed treatment with NSAIDs and non opioid co-analgesics such as anticonvulsant medications. The guidelines did not support prescription of opioid refills because regular clinic evaluation is necessary to document compliance, functional restoration and continual requirement for opioid medications. The criteria for the use of Hydrocodone/APAP 10/325mg #180 2 Refills was not met. The request is not medically necessary.