

<b>Case Number:</b>	CM14-0147604		
<b>Date Assigned:</b>	09/15/2014	<b>Date of Injury:</b>	01/14/2010
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	08/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2014

### 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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Georgia. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 claimant is a 39 year old female presenting with chronic pain following a work related injury on 01/14/2010. The claimant reported neck, low back and bilateral lower extremity pain as well as right arm, right wrist/hand and right hip pain. The claimant was diagnosed with lumbar disc displacement, cervical, and lumbar disc disease, radiculitis, sciatica, coccydynia, neck, low back and thoracic pain. The lumbar MRI on 06/12/13 showed left L4-5 disc extrusion. Electrodiagnostic studies of the upper extremities on 06/14/2012 showed mild to moderate right carpal tunnel syndrome and no cervical radiculopathy. The physical exam showed tender lumbar spine, positive straight leg raise, tenderness to palpation in the trapezius, and rhomboids bilaterally. The claimant's medications included Ketoprofen, Prilosec, Hydrocodone, and Orphendadrine which provided 25-50% relief with an 8/10 pain score. A claim was placed for Robaxin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone/APAP 5/325mg tablet one twice daily:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79.

**Decision rationale:** Per MTUS Page 79 of MTUS guidelines states that weaning of opioids are recommended if (a) there are no overall improvement in function, unless there are extenuating circumstances (b) continuing pain with evidence of intolerable adverse effects (c) decrease in functioning (d) resolution of pain (e) if serious non-adherence is occurring (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. The claimant has long-term use with this medication and there was a lack of improved function with this opioid. In fact the claimant was designated permanent and stationary; therefore the requested medication is not medically necessary.