

<b>Case Number:</b>	CM14-0162584		
<b>Date Assigned:</b>	10/07/2014	<b>Date of Injury:</b>	12/15/2008
<b>Decision Date:</b>	11/07/2014	<b>UR Denial Date:</b>	09/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/03/2014

### 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 Anesthesiologist, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 injured worker is a 51-year-old female who reported an injury on 12/15/2008. The mechanism of injury was not submitted for clinical review. The diagnoses included status post fluoroscopically guided right sacroiliac joint injection, right hip pain, right sacroiliac joint injection, right sacroiliitis, lumbar disc protrusion, lumbar stenosis, lumbar degenerative disc disease, lower lumbar facet joint arthropathy, bilateral knee pain, and right thumb pain. The previous treatments included medications and injections. Within the clinical note dated 08/25/2014 it was reported the injured worker complained of dull right hip pain. The injured worker reported the injections had no relief of pain. The injured worker complained of left knee pain with popping, clicking, and instability. She reported having persistent low back pain, muscle spasms, stiffness, and tightness. Upon physical examination the provider noted the injured worker had tenderness across the lumbar paraspinal muscles. The range of motion of the lumbar spine was flexion at 30 degrees, and extension at 10 degrees. The provider noted the injured worker had pain along the medial, greater, and lateral joint line. The injured worker had a negative Patrick's test. The provider requested hydrocodone/acetaminophen. However, a rationale was not submitted for review. The Request for Authorization was submitted and dated 08/25/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective request for Hydrocodone/Acetaminophen 10/325mg QTY: 160.00 (DOS 8/25/2014): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management, Page(s): page(s) 78. .

**Decision rationale:** The retrospective request for hydrocodone/acetaminophen 10/325mg QTY: 160.00 (DOS 8/25/2014) is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency for the medication. The provider failed to document an adequate and complete pain assessment within the documentation. The use of a urine drug screen was not submitted for clinical review. Therefore, the request is not medically necessary.