

<b>Case Number:</b>	CM14-0180160		
<b>Date Assigned:</b>	11/04/2014	<b>Date of Injury:</b>	01/10/2009
<b>Decision Date:</b>	12/09/2014	<b>UR Denial Date:</b>	10/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2014

### 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 Neurology; has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 patient is a 46-year-old woman who sustained a work-related injury on January 10, 2009. Subsequently, she developed bilateral upper extremity pain. The patient had a permanent spinal cord stimulator implant in June 2011 and underwent left ulnar nerve transposition in December 2009. According to the evaluation report dated October 1, 2014, the patient complained of bilateral upper extremity pain with numbness and paresthesias. Her physical examination revealed abnormal swelling and mottled color in the left hand, and there was temperature changes with the left upper extremity being cooler than the right upper extremity. There was tenderness upon palpation of the left upper extremity, where there was hypersensitivity. There was allodynia and hypesthesia of the left elbow and left upper extremity. There were positive trophic changes of the left upper extremity. Cervical, left hand, and forearm ranges of motion were restricted by pain in all directions. Cervical discogenic, left hand, and forearm provocative maneuvers were positive. Nerve root tension signs were negative bilaterally. Muscle stretch reflexes were symmetric bilaterally in all limbs, clonus, Babinski's, and Hoffmann's signs were absent bilaterally. Muscle strength was 5/5 in all limbs. Sensation was intact to light touch, pinprick, proprioception, and vibration in all limbs, except for hypersensitivity and decreased sensation to all modalities in the left arm. The patient was diagnosed with status post permanent spinal cord stimulator implant, bilateral upper extremity chronic regional pain syndrome/reflex sympathetic dystrophy, right shoulder tendinitis, left shoulder tendinitis with impingement, left shoulder adhesive capsulitis, status post left elbow ulnar nerve surgery, and left shoulder internal derangement. According to [REDACTED], the hydrocodone did provide 40% decrease of the patient's pain with 40% improvement of the patient's activities of daily living. He noted that the patient is on an up-to-date pain contract, the patient's previous UDS was consistent, and the medication has no adverse effects on the patient. He stated that the patient has failed physical

therapy, NSAIDs, and conservative treatments. The provider requested authorization for RETROSPECTIVE Hydrocodone 10/325mg.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Retrospective Hydrocodone 10/325mg #30 (Date of service: 8/6/14): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, on-going management.

**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, Norco (Hydrocodone/Acetaminophen) 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 treated with Hydrocodone without any evidence of objective pain and functional improvement. There is no documentation that the patient was involved in a rehabilitation program to consolidate the effect of her medications. Therefore, the prescription of Retrospective Hydrocodone 10/325mg #30 (Date of service: 8/6/14) is not medically necessary.