

<b>Case Number:</b>	CM15-0011756		
<b>Date Assigned:</b>	01/29/2015	<b>Date of Injury:</b>	06/15/2006
<b>Decision Date:</b>	03/19/2015	<b>UR Denial Date:</b>	01/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/20/2015

### 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: New York, West Virginia, Pennsylvania  
 Certification(s)/Specialty: Emergency Medicine

### 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 61 year old male with an industrial injury date of 06/15/2006. The mechanism of injury is documented as while working as a diesel mechanic a ratchet he was working broke off causing him to land on his tailbone. Later he had increased numbness down the right leg and underwent lumbar 5-sacral 1 decompression on 06/23/2009 with right lower extremity pain. He continues to have pain across his back. He rates the pain as 7/10 and describes it as aching and throbbing. Physical exam revealed restricted range of motion with extension limited to 20 degrees. Current medications include MS Contin, Norco, Amlodipine and Paroxetine. Other treatments include manual muscle testing procedure, diagnostics, surgery and radio frequency ablation. Diagnoses included lumbago, facet syndrome and post-laminectomy syndrome of lumbar region. On 01/06/2015 utilization review denied the request for new start of Morphine Sulfate ER 15 mg # 90 30 day supply. MTUS was cited. The request for refill of Hydrocodone/APAP # 120, 30 day supply was denied. A one time fill of Hydrocodone/APAP was approved on 12/31/2014. MTUS was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Morphine Sulfate ER 15mg #90, prescribed 12/23/2014: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 76-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-80.

**Decision rationale:** The California Medical Treatment Utilization Schedule requires ongoing documentation of pain relief, functional status, appropriate medication use, and side effects for patient who are on opioids chronically. The medical records do not show documentation of functional benefit despite the use of chronic opioids including Norco and MS Contin. The addition of a third opioid is not supported.

**Hydrocodone/APAP 10/325mg #120, prescribed 12/23/2014:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 76-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-80.

**Decision rationale:** California MTUS requires documentation of continuous pain relief, functional status, appropriate medication use, and side effects for patients using opioids chronically. The medical chart does not document analgesic benefit and there is no documentation of functional improvements with use of opioids. The use of chronic opioids is not supported.