

<b>Case Number:</b>	CM15-0066495		
<b>Date Assigned:</b>	04/14/2015	<b>Date of Injury:</b>	05/07/1993
<b>Decision Date:</b>	05/13/2015	<b>UR Denial Date:</b>	03/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/08/2015

### 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: Arizona, California  
 Certification(s)/Specialty: Family Practice

### 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 56 year old male who sustained an industrial injury on 05/07/1993. Current diagnoses include multi-level disc disease, disc protrusion, and subacromial impingement right shoulder. Previous treatments included medication management, and gym program. Previous diagnostic studies included MRI of the lumbar spine and x-rays of both knees. Report dated 03/19/2015 noted that the injured worker presented with complaints that included continued low back pain with radiation down the left leg and numbness. Pain level was rated as 8 out of 10 on the visual analog scale (VAS). Current medications include Flector patches, hydrocodone/acetaminophen, and omeprazole Physical examination was positive for abnormal findings. The treatment plan included a request for medication. Disputed treatments include hydrocodone 10/325mg #60, with 3 refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone 10/325mg #60, with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Goodman and Gilman's The Pharmacological Basis of Therapeutics, 12th Ed. McGraw Hill, 2010; Physician's Desk Reference, 68th Ed.; and Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone Page(s): 82-92.

**Decision rationale:** Hydrocodone is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Hydrocodone for several months. The pain recently was noted to be 8/10 but reduction level with medication with medication was not noted. Consistent VAS scores were not noted. In addition, advance request for 3 months refills without knowing claimant physical response is not indicated. Continued use of Hydrocodone is not medically necessary.