

<b>Case Number:</b>	CM15-0075077		
<b>Date Assigned:</b>	04/24/2015	<b>Date of Injury:</b>	05/01/2012
<b>Decision Date:</b>	05/26/2015	<b>UR Denial Date:</b>	04/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/20/2015

### 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: California  
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 53 year old female, who sustained an industrial injury on 5/01/2012. The medical records submitted for this review did not include the details regarding the initial injury. Diagnoses include post traumatic low back pain with underlying discogenic disease, degenerative disc disease, radicular pain and greater trochanteric bursitis. Treatments to date include medication therapy, epidural steroid injections, and physical therapy. Currently, she complained of back pain rated 10/10 VAS without medication. On 3/16/15, the physical examination documented lumbar tenderness with 4+ muscle spasms and positive straight leg raise. The plan of care included continuation of medication therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone 10/325mg QTY: 180.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82 Page(s): 78-82.

**Decision rationale:** The requested Hydrocodone 10/325mg QTY: 180.00, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has back pain rated 10/10 VAS without medication. On 3/16/15, the physical examination documented lumbar tenderness with 4+ muscle spasms and positive straight leg raise. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract or urine drug screening. The criteria noted above not having been met, Hydrocodone 10/325mg QTY: 180.00 is not medically necessary.