

<b>Case Number:</b>	CM15-0090912		
<b>Date Assigned:</b>	05/15/2015	<b>Date of Injury:</b>	07/09/1991
<b>Decision Date:</b>	06/23/2015	<b>UR Denial Date:</b>	04/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/11/2015

### 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: Preventive Medicine, Occupational 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 71 year old male, who sustained an industrial injury on 7/9/1991. He reported injury from a fall, while using a forklift. The injured worker was diagnosed as having lumbosacral disc degeneration and right total knee replacement. There is no record of a recent diagnostic study. Treatment to date has included surgery, physical therapy, epidural steroid injection and medication management. In a progress note dated 3/13/2015, the injured worker complains of low back pain with radiation to the bilateral lower extremities. Pain was rated 8/10 with medications. The treating physician is requesting Hydrocodone/Acetaminophen 10/325 mg #240.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone/Acetaminophen 10/325mg #240:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 74-94.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of Norco, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. Hydrocodone/Acetaminophen 10/325mg #240 is not medically necessary.