

Case Number:	CM13-0043874		
Date Assigned:	12/27/2013	Date of Injury:	09/21/2012
Decision Date:	03/07/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/31/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Medicine, and is licensed to practice in Utah. 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 physician 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 34 year old female. She has a date of injury of 9/21/2012. Her injury was a trip over a stool next to her desk, which resulted in pain in the low back and leg. Her diagnosis includes Lumbar Disc Displacement. Her treatment course has included physical therapy, medications, ice/warm packs, back supports, activity modifications, orthotics, chiropractor treatments, and lumbar injections. An MRI study was performed on 4/16/13 which showed a L5-S1 right paracentral disc protrusion, which slightly displaces the S1 nerve and a L5-S1 moderated epidural lipomatosis, congenital central canal stenosis. A physical exam document shows findings showed a painful range of motion and a positive seated leg raise exam. Another documented clinical exam on 6/5/2013, shows tenderness to palpation in the paraspinal area, but no midline tenderness or bony step offs. Neurological exam was normal reflexes and normal muscle tone. Exam documents from 2/26/2013 state there is no improvement in her pain levels. She was previous prescribed Norco twice daily, but the dates are not clear. The clinical documents state that she continues to have pain, described as burning and stabbing pain. There is no clear documentation that states an improvement with her pain on her previous course of Norco.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medication: Norco: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Back.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75-79.

Decision rationale: The MTUS Chronic Pain Guidelines were reviewed in regards to this specific case. The clinical documents were reviewed. According to the medical records provided for review, Norco was noted to have been used previously, twice daily, but exact dates are unclear in the documents. No documented significant changes in clinical findings were noted. Exam documents from 2/26/2013 state there was no improvement in her pain levels. According to the documentation provided, there has been no significant change in character of the pain; the pain appears to be chronic, lacking indications for fast acting pain control medications. Consequently, the request is not medically necessary and appropriate.