

Case Number:	CM13-0047022		
Date Assigned:	12/27/2013	Date of Injury:	03/02/2011
Decision Date:	03/31/2014	UR Denial Date:	10/11/2013
Priority:	Standard	Application Received:	11/04/2013

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 Internal Medicine & Emergency Medicine and is licensed to practice in Florida. 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:

This patient is a 43 year-old injured worker with a date of injury of 03/02/11. The mechanism of injury was not specified. A progress report included by [REDACTED], dated 09/20/13, identified subjective complaints of low back pain radiating into the left leg as well as numbness of both hands. Objective findings included tenderness to palpation of the sacroiliac, sciatic notch, and lumbar paraspinal areas. There was decreased sensation in the left lower extremity and mild decrease in strength on that side. Diagnoses include cervical disc disease, C3 through C7 and lumbar disc disease L2 through L5. Treatment has included epidural steroid injections, opioids in excess of six months, and Bio-Therm cream. Pain is reported as decreased from 9/10 to 6-7/10 after taking medications. A Utilization Review determination was rendered on 10/11/13 recommending non-certification of "Norco 10/325mg, #120".

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-83.

Decision rationale: The patient is on chronic Norco 10/325. This is classified as an opioid analgesic in combination with acetaminophen. The MTUS Chronic Pain Medical Treatment Guidelines related to on-going treatment of opioids state that there should be documentation and ongoing review of pain relief, functional status, appropriate use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. A recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of the key outcome goals including pain relief, improved quality of life, and/or improved functional capacity (Eriksen 2006). The documentation submitted for review lacked a number of the elements listed above, including the level of functional improvement afforded by the chronic opioid therapy. The MTUS Guidelines also state that with chronic low back pain, opioid therapy "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (> 16 weeks), but also appears limited." Additionally, "There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain (Martell - Annals, 2007)." The patient has been on opioids well in excess of 16 weeks. In this case, though there is description of the level of pain relief, there is no documentation of the other elements of the pain assessment referenced above for needed necessity of therapy beyond 16 weeks where the evidence is otherwise unclear. The request for Norco 10/325mg, # 120 is not medically necessary and appropriate.