

Case Number:	CM13-0048571		
Date Assigned:	04/16/2014	Date of Injury:	08/05/2011
Decision Date:	06/30/2014	UR Denial Date:	10/25/2013
Priority:	Standard	Application Received:	11/06/2013

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 Neurology, has a subspecialty in Neuromuscular Medicine, and is licensed to practice in California. 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:

██████████ is a 52 year old woman who sustained a work related injury on August 5 2011. Subsequently, she developed right hand, left knee and cervical pain. The patient has an EMG/NCV on September 2012 demonstrated generalized distal axonal sensorimotor polyneuropathy. Her lumbar and cervical MRI performed on 2012 showed neural foraminal narrowing. According to a note dated on September 30, 2013, the patient was complaining of ongoing neck and back pain as well as right wrist brace. Her physical examination demonstrated tenderness in the cervical and lumbar spine with reduced range of motion. The provider requested authorization to use the medication mentioned below.

IMR ISSUES, DECISIONS AND RATIONALES

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

HYDROCODONE/APAP 10/325: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN TREATMENT GUIDELINES, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES CRITERIA FOR USE OF OPIOIDS Page(s): 179.

Decision rationale: According to MTUS guidelines, Norco (Hydrocodone/Acetaminophen) is a synthetic opioid indicated for pain management, but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: a) Prescriptions are to come from a single practitioner, taken as directed, and all prescriptions are to come from a single pharmacy; b) The lowest possible dose should be prescribed to improve pain and function; and c) Required is ongoing review and documentation of pain relief, functional status, appropriate medication 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 the pain relief lasts. There is no clear evidence of objective and recent functional and pain improvement with previous use of opioids (Norco). There is no clear documentation of the efficacy/safety of previous use of Hydrocodone/Acetaminophen. There is no clear justification for the need to continue the use of Hydrocodone/Acetaminophen. Therefore, the prescription for hydrocodone/APAP 10/325 is not medically necessary at this time.

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES PERCUTANEOUS ELECTRICAL NERVE STIMULATION Page(s): 97.

Decision rationale: According to the MTUS guidelines, TENS is not recommended as a primary treatment modality, but a one month based trial may be considered, if used as an adjunct to a functional restoration program. There is no evidence that a functional restoration program is planned for this employee. Furthermore, there no clear documentation functional improvement with previous TENS use or documentation of one month trial of TENS. Therefore, the prescription for Transcutaneous Electrical Nerve Stimulation (TENS) Unit is not medically necessary.