

Case Number:	CM13-0067500		
Date Assigned:	01/03/2014	Date of Injury:	07/11/1998
Decision Date:	07/07/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	12/17/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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/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 injured worker is a 58-year-old female who reported an injury on 07/11/1998. The mechanism of injury was not provided. The injured worker complained on 02/19/2014 of bilateral lower extremity pain in the hip on the left and right and low back pain. It was stated that spinal cord stimulation was discussed with the injured worker and she states that spinal cord stimulation was the cause of her current pain. On the physical examination the injured worker was in severe pain with limited mobility while moving her legs. It was noted the injured worker had severe degenerative disease of her right hip and failed back surgery syndrome. The diagnoses of the injured worker were listed as lumbar post-laminectomy syndrome, bilateral lower extremity radiculopathy, disc replacement, cervical spine syndrome and severe depression. Medications included, Norco 10/325 mg, Prilosec 20 mg, and Fexmid 7.5 mg. The treatment plan included a refill of Norco 10/135 mg for the injured worker's bilateral hip and back pain. There was no authorization form submitted with this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/135MG QID #120: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 78.

Decision rationale: The injured worker complained of persistent pain of her low back and bilateral hip. There is ongoing documentation indicated Norco 10/325mg prescription from 01/10/2014. The California Medical Treatment Utilization Schedule (MTUS) guidelines state that criteria for use for ongoing- management of opioids include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There is lack of documentation stating the efficacy of the Norco 10/325 mg of the medication. There is a lack of documentation regarding current pain on a VAS scale, average pain, intensity of pain, or longevity of pain relief. There is a lack of documentation regarding consistent urine drug screens. In addition, there is no indication provided of the side effects. Given the above, the request for the ongoing use of Norco is not supported by the California Medical Treatment Utilization Schedule (MTUS) guidelines recommendations. As such the request is not medically necessary.