

Case Number:	CM14-0009883		
Date Assigned:	02/21/2014	Date of Injury:	06/03/2004
Decision Date:	06/25/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	01/27/2014

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 Texas. 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 56 year old male injured on 06/03/14 while pulling a body out of a van onto a loading dock. Current diagnoses include left L5-S1 radiculitis, left decreased dorsa flexion clearance, low back pain, and paresthasias. The injured worker has previously undergone physical therapy, epidural steroid injections, and medication management. The documentation dated 01/10/14 indicated the injured worker suffers frequent falls due to sudden weakness in the lower extremities causing him to catch his feet and trip and fall. A physical examination was not provided. Current medications include Zanaflex 4mg twice daily, Norco three times daily, Ambien 10mg, and Lidoderm patch. The injured worker also utilizes a Transcutaneous Electrical Nerve Stimulation (TENS) unit. Previous utilization review indicated that prior certifications of medication was based on appropriate documentation of improved functionality and appropriate assessment of pain management. The initial request for retrospective Norco/Hydrocodone 10mg, quantity 90 (01/10/14) was initially non-certified on 01/17/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE NORCO/HYDROCODONE 10 MG QUANTITY 90 (1/10/2014):

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 78 & 81 of 127..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines 9792.20, Opioids, criteria for use Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. In addition, no recent opioid risk assessments regarding possible dependence or diversion were available for review. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the request for Retrospective Norco/Hydrocodone 10 mg quantity 90 (1/10/2014) is not medically necessary.