

Case Number:	CM14-0010772		
Date Assigned:	02/21/2014	Date of Injury:	12/23/1998
Decision Date:	07/24/2014	UR Denial Date:	01/07/2014
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 Anesthesiology has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 patient is a 38-year-old male who has submitted a claim for lumbar disc degeneration, chronic pain disorder, lumbar facet arthropathy, lumbar radiculitis, anxiety, depression, coccygodynia status post left inguinal hernia repair associated with an industrial injury date of December 23, 1998. Medical records from 2013-2014 were reviewed. The patient complained of chronic low back pain, grade 4-8 in severity. The back pain radiates to the right lower extremities to the thigh. It was aggravated by activity and walking. Physical examination showed the patient in moderate distress. There was lumbar myofascial and spinal paravertebral tenderness noted at L4-S1 levels. There was reduced range of motion of the lumbar spine secondary to pain. Motor exam showed decreased strength of the bilateral lower extremities. Bilateral straight leg raise test was negative. MRI of the lumbar spine, dated May 19, 2012, revealed L4-L5 diffuse disc protrusion with effacement of the thecal sac, bilateral neuroforaminal narrowing that effaces left/right L4 exiting nerve roots, and no significant difference with pre and post load bearing. Treatment to date has included medications, activity modification, left inguinal hernia repair and lumbar epidural steroid injection. Utilization review, dated January 7, 2014, denied the request for Norco 10/32mg #120 because no overall functional improvement with continued use of this medication was noted. The request for Butrans 15mcg/hr was denied as well because there was no mention in the documentation that the patient has an opiate addiction.

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 Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 78.

Decision rationale: As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief (analgesia), side effects (adverse side effects), physical and psychosocial functioning (activities of daily living) and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been taking Norco since July 2013. There was no documented evidence of functional benefit from the intake of the medication. Specific measures of analgesia and functional improvements such as improvements in activities of daily living were not documented as well. There was also no documentation of adverse effects or aberrant drug-taking behaviors. There were no side effects noted. MTUS Guidelines require clear and concise documentation for ongoing management. The guideline criteria have not been met. Therefore, the request for Norco 10/325mg #120 is not medically necessary.

BUTRANS 15MCG/HR: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines BUPRENORPHINE Page(s): 26-27.

Decision rationale: Pages 26 to 27 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that Buprenorphine is recommended for treatment of opiate addiction. In this case, the patient was prescribed Butrans in July 2013. However, the medical records did not document objective measures of analgesia and functional gains attributed with the use of Butrans. In addition, the medical records also failed to provide evidence of history of opiate addiction. There is no clear indication for continued use of this medication. Furthermore, the present request failed to specify the quantity to be dispensed. Therefore, the request for Butrans 15 Mcg/Hr is not medically necessary.