

Case Number:	CM14-0110837		
Date Assigned:	09/16/2014	Date of Injury:	12/01/2004
Decision Date:	10/22/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/16/2014

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 & 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 39-year-old female who reported an injury on 12/01/2004. The mechanism of injury was not submitted for clinical review. The diagnoses include thoracic disc degeneration, compression fracture, lumbar radiculopathy, and chronic pain. Previous treatments included medication and TENS unit. Diagnostic testing included an MRI. Within the clinical note dated 01/06/2014, it was reported the injured worker complained of thoracic back pain. She reported the pain radiated down the bilateral lower extremities. She described the pain as aching, burning, electricity sensation, stabbing in nature. The injured worker complained of frequent, severe, muscle spasms in the low back. She rated her pain 6/10 to 7/10 in severity with medication, and 9/10 in severity without medication. Upon the physical examination, the provider noted the lumbar spine revealed tenderness upon palpation of the spinal vertebral area L4-S1. The range of motion of the lumbar spine was moderately limited secondary to pain. The sensory exam noted decreased sensation to touch along the L5-S1 dermatome in both lower extremities. The request submitted is for Norco 10/325 mg #150 with 1 refill. However, a rationale is not submitted for clinical review. However, a rationale is not submitted for clinical review. The Request for Authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prescription for Norco 10/325mg, #150 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78..

Decision rationale: The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The provider failed to document an adequate and complete pain assessment within the physical exam. Additionally, the use of a urine drug screen was not submitted for clinical review. Therefore, Norco 10/325 #150 with 1 refill is not medically necessary.