

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0119286 | | |
| Date Assigned: | 08/06/2014 | Date of Injury: | 01/17/2014 |
| Decision Date: | 09/10/2014 | UR Denial Date: | 07/22/2014 |
| Priority: | Standard | Application Received: | 07/28/2014 |

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 California and Washington. 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 injury on 01/17/2002. The mechanism of injury was not provided. The diagnostic studies were not provided. The documentation of 04/24/2014 revealed the injured worker indicated that she had pain in multiple areas including her neck and back. Upon examination, the injured worker had tenderness in the lower lumbar paravertebral musculature, posterior cervical and bilateral trapezius musculature. The diagnoses included chronic right lateral epicondylitis, status post right first dorsal compartment release with residuals, status post lumbar fusion L3-4, cervical spondylosis, anterior talofibular ligament injury left ankle, and status post right knee arthroscopy with chondromalacia of the patella and pes anserine bursitis. The treatment plan included a neurologist evaluation, an ENT evaluation, and Norco 5/325 mg 1 by mouth daily to twice a day #45 with 2 refills. There was a detailed DWC form RFA submitted for the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325 mg #45, 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, page 60, ongoing management Page(s): 78.

Decision rationale: The California MTUS Guidelines recommend opioids for the treatment of chronic pain. There should be documentation of objective functional improvement, and objective decrease in pain and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to meet the above criteria. The duration of use could not be established through supplied documentation. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documentation indicating a necessity for 2 refills without reevaluation. Given the above, the request for Norco 5/325 mg #45 two refills is not medically necessary.