

Case Number:	CM14-0173820		
Date Assigned:	10/27/2014	Date of Injury:	11/12/2012
Decision Date:	12/03/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/21/2014

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 Neurology; has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 39-year-old man who sustained a work related injury on November 12, 2012. Subsequently, he developed chronic neck and back pain. X-ray study of the lumbar spine done on November 12, 2012 was unremarkable. MRI of the lumbar spine completed on February 7, 2013 showed very mild early disc degeneration and facet degenerative changes of the lower lumbar spine without fracture, spondylolisthesis or central canal stenosis. EMG study of the lower extremities performed on July 3, 2013 documented normal electrodiagnostic studies of the bilateral lower extremities. There was no strong evidence consistent with a denervating right or left lumbosacral radiculopathy, plexopathy, polyneuropathy, or tarsal tunnel syndrome. borderline irritability noted in the left extensor digitorum brevis muscle, which may be secondary to localized trauma. The patient has been through conservative treatments that included medications, TENS unit, acupuncture, back brace, physical therapy, chiropractic, and home exercise program. According to the follow-up report dated September 18, 2014, the patient complained lower back pain. He rated the pain as a 6/10. The pain was characterized as aching, burning, and pricking. He stated that medications are helping. On examination, the patient had an antalgic gait. The lumbar range of motion was restricted with flexion limited to 80 degrees limited by pain and extension limited to 10 degrees limited by pain. Straight leg raising test was positive on both sides at 90 degrees in sitting position. Power of knee flexor's was 4/5 on right and 4/5 on left, knee extensor's was 5/5 on right and 5/5 on left. Light touch sensation was normal all over the body. There was lumbar midline tenderness with palpation, mild edema, and warm to the touch. The patient was diagnosed with lumbago, sprain/strain of neck, thoracic or lumbosacral Neuritis or Radiculitis, and Cervicalgia. The provider requested authorization for Norco.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325mg 330: 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 Criteria for use of opioids Page(s): 76-79.

Decision rationale: According to MTUS guidelines, Norco (Hydrocodone/Acetaminophen) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules:(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. According to the patient file, there is no objective documentation of functional improvement. There is no documentation of current UDS to document the patient compliance and to rule out any drug abuse. There is no documented updated and signed pain contract. Therefore, the prescription of Norco 5/325mg #330 is not medically necessary.