MAXIMUS Federal Services

Case Number:	CM14-0024266		
Date Assigned:	06/11/2014	Date of Injury:	01/09/2002
Decision Date:	07/15/2014	UR Denial Date:	02/12/2014
Priority:	Standard	Application Received:	02/26/2014

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 Occupational Medicine and is licensed to practice in California. 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 claimant was injured on 01/09/02 and has affective psychosis. Norco from 02/06/14 through 03/23/14 is under review. On 10/21/13, [redacted] dated she was disorganized and probably delirious and had been falling. She was confused and disoriented. This seemed to be combination of Parkinson's disease and possible medication. On 11/18/13, she saw [redacted] and was struggling with depression. She was more depressed, but he did not want to change her medication. She remained on Effexor and Prozac for depression. She was much better than the week before when she was delirious. The claimant saw [redacted] on 01/13/14 and was a little a better in terms of her mood. She was not as depressed as before. She was not as labile or as acutely suicidal. She was struggling with Parkinson's disease. Her neck and back pain remained. She was given a refill of the medications Norco 10/325 mg four times a day as well as ibuprofen and Depakote ER. She was a little less depressed. On 01/20/14, she was prescribed oxycodone 5 mg three times a day. She was also taking Cymbalta, Celexa, and Ambien for sleep and Klonopin for anxiety. Her medications were being denied including fentanyl patch. Oxycodone was increased. On 02/05/14, she was evaluated and had right-sided low back pain. She needed minimal assistance from others. She could ambulate one city block with no assistive devices and had difficulty transferring out of a chair. She had been taking Neurontin which gave her a 20% decrease in pain. She had increased low back pain over the past three weeks due to the weather. She had difficulty finding a position of comfort. Her medications included gabapentin, Percocet, Prilosec, Prozac, and tizanidine. She had a depressed and flat affect.

IMR ISSUES, DECISIONS AND RATIONALES

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

120 TABLETS OF NORCO 10/325MG BETWEEN 2/6/2014 AND 3/23/2014: 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: The history and documentation do not objectively support the request for the opioid, Norco from 02/06/14 through 03/23/14. The California Medical Treatment Utilization Schedule (MTUS) outlines several components of initiating and continuing opioid treatment and states "a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." In these records, there is no documentation of trials and subsequent failure of or intolerance to first-line drugs such as acetaminophen or non-steroidal anti-inflammatory drugs. MTUS further explains, "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." There is also no indication that periodic monitoring of the claimant's pattern of use and a response to this medication, including assessment of pain relief and functional benefit, has been or will be done. There is no evidence that she has been involved in an ongoing rehab program to help maintain any benefits she received from treatment measures. Additionally, the 4A's "analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors" should be followed and documented per the guidelines. The claimant's pattern of use of Norco is unclear. There is no evidence that a signed pain agreement is on file at the provider's office and no evidence that a pain diary has been recommended. As such, the medical necessity of the ongoing use of Norco has not been clearly demonstrated.