

Case Number:	CM14-0026445		
Date Assigned:	06/13/2014	Date of Injury:	07/11/2007
Decision Date:	08/25/2014	UR Denial Date:	02/21/2014
Priority:	Standard	Application Received:	03/03/2014

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. 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:

This is a 44-year-old male with a 7/11/07 date of injury. The mechanism of injury was not noted. According to a 2/11/14, progress note the patient was feeling pain in his legs and went to the ER. He felt better so he returned home. He noted no change in baseline pain with continued numbness in the bilateral upper and lower extremities. A stable orthopedic exam was reported with no change in the last year. The patient also complained of constipation. Objective findings: no change since last examination, severe facial tremor, depression, mild distress with difficulty rising from seated, bilateral muscle spasm and tenderness reported with cervical tenderness, decreased sensation in the C6 dermatome and no atrophy of the upper extremity. Diagnostic impression: right upper extremity myelopathy with tremor; post concussive syndrome; cervical spine HNP; T6 compound fracture healed; status post hernia repair; gastritis; stress/anxiety; sexual dysfunction. Treatment to date includes medication management, activity modification and surgery. A UR decision dated 2/22/14 modified the request for Norco 10/325 mg #90 with 1 refill to certify 1 prescription of Norco 10/325 mg 72 tablets for weaning purposes and denied the request for 1 range of motion/muscle test. A specific rationale was not provided regarding the decision for Norco. Regarding range of motion/muscle testing, guidelines note that the relation between back range of motion measures and functional ability is weak or nonexistent. Therefore, this request is not medically necessary based on the lack of guideline support.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325 MG # 90 WITH (1) REFILL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In the reports reviewed, there is no documentation of significant pain reduction or improved activities of daily living. In addition, according to a 2/11/14 progress note, the patient stated that his functional status has not changed since last visit despite the continued use of Norco. Furthermore, there is no documentation of lack of aberrant behavior or adverse side effects, an opioid pain contract, or a urine drug screen. Therefore, the request for Norco 10/325 MG # 90 with (1) refill was is medically necessary.

(1) RANGE OF MOTION/MUSCLE TEST: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

Decision rationale: The California MTUS does not address this issue. The Official Disability Guidelines states that flexibility should be a part of a routine musculoskeletal evaluation, and does not recommend computerized measures of lumbar spine range of motion, which can be done with inclinometers, and where the result (range of motion) is of unclear therapeutic value. The AMA Guides to the Evaluation of Permanent Impairment, 5th edition, state, an inclinometer is the preferred device for obtaining accurate, reproducible measurements in a simple, practical and inexpensive way. A specific rationale identifying why a computerized measure of lumbar spine range of motion would be required in this patient despite lack of guideline support was not identified. Therefore, the request for (1) Range of motion/muscle test was not medically necessary.