

<b>Case Number:</b>	CM14-0064791		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	04/19/2011
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	05/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2014

### 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 Pain 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 injured worker is a 54-year-old male who reported an injury on 04/19/2011. The mechanism of injury was not provided. On 02/19/2014, the injured worker presented with back and lower extremity pain and weakness in the alternating leg cramping. Also noted dysesthesias of the bilateral feet. Upon examination, there was a slow gait with a single-point cane and bilateral give-way weakness of the quadriceps and mild hamstring weakness bilaterally. There was 4/5 left dorsiflexion weakness and mild decreased sensation of the right anterior thigh and a positive straight leg raise to the left. An EMG from 02/05/2014 revealed limited electrodiagnostic evidence to suggest chronic lumbar radiculitis. Diagnoses were status post anterior/posterior lumbar fusion L4-S1 with persistent lumbago, lower extremity weakness, and cramping. A current medication list was not provided. The provider recommended Norco; the provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #80 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78, 91.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

**Decision rationale:** The request for Norco 10/325 mg with a quantity of 80 and 2 refills is not medically necessary. The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of evidence of an objective assessment of the injured worker's pain level, functional status, and evaluation of risk for aberrant drug abuse behavior and side effects. Additionally, the efficacy of the prior use of Norco was not provided. The provider's request for Norco does not indicate the frequency of the medication in the request as submitted. Therefore, the request is not medically necessary.