

<b>Case Number:</b>	CM15-0134075		
<b>Date Assigned:</b>	07/22/2015	<b>Date of Injury:</b>	02/19/1998
<b>Decision Date:</b>	08/19/2015	<b>UR Denial Date:</b>	06/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New Jersey, New York

Certification(s)/Specialty: Family Practice

### 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 64 year old male who sustained an industrial injury on 02/19/1998. The injured worker was diagnosed with cervical degenerative disc disease, cervical spondylosis, cervicgia and myalgia. No surgical interventions or therapies were documented. Treatment to date was noted as pharmacological management. According to the primary treating physician's progress report on June 9, 2015, the injured worker continues to experience chronic neck pain. The injured worker rates his pain level at 4/10 with medications and 8/10 without medications. Examination of the cervical spine demonstrated tenderness over the cervical paraspinal muscles with decreased range of motion in all planes and positive Spurling's bilaterally. Hoffman's sign was negative bilaterally. Motor strength was 5/5 in the upper extremities with decreased sensation in the bilateral C6 dermatomes. Upper extremity deep tendon reflexes were 1+ and symmetric. Current medications are listed as Norco 10/325mg, Prevacid and Skelaxin. Treatment plan consists of the current request for Norco 10/325mg renewal.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 prescription of Norco 10/325mg #110: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list, Hydrocodone/Acetaminophen; Opioids for chronic pain; Opioids,

long-term assessment, Criteria for Use of Opioids, Long-term Users of Opioids (6-months or more); Weaning of Medications.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-79.

**Decision rationale:** The request is considered medically necessary. The patient has had documented decrease in pain and improvement in function with the use of Norco. The patient had consistent urine drug screens and documented drug contract. There were no side effects documented. The patient had appropriate monitoring using the 4 A's. The patient has been on Norco long-term and will be weaning off with this prescription to avoid withdrawal symptoms. Therefore, the request is medically necessary.