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| Case Number: | CM15-0168772 | | |
| Date Assigned: | 09/09/2015 | Date of Injury: | 09/23/2008 |
| Decision Date: | 10/08/2015 | UR Denial Date: | 08/14/2015 |
| Priority: | Standard | Application Received: | 08/27/2015 |

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

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 48 year old male, who sustained an industrial-work injury on 9-23-08. He reported initial complaints of back pain. The injured worker was diagnosed as having low back pain with radiculopathy in right leg. Treatment to date has included medication, home exercise regimen and diagnostics. MRI results were reported disc herniation at L5-S1 impinging right S1 nerve root and EMG (electromyogram) revealing chronic S1 radiculopathy in right leg. Currently, the injured worker complains of low back pain with radiation into the legs. Pain was rated from 10 out of 10 without medication to 4 out of 10 with medication. Per the primary physician's progress report (PR-2) on 7-28-15, exam noted an antalgic gait, reduced range of motion, reduced muscle strength, loss of deep tendon reflex on the right Achilles. Current plan of care includes pain medication. The Request for authorization date was 7-30-15 and requested service included Norco 10/325mg #140. The utilization review on 8-14-15 denied the request due to long term use (since at least April 2013) and failed documentation of functional improvement and lack of weaning.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #140: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: Norco 10/325mg #140 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS Chronic Pain Medical Treatment Guidelines state that a 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. The MTUS does not support ongoing opioid use without improvement in function or pain. The documentation reveals that the patient has been on long term opioids without significant objective measurable functional improvement therefore the request for continued Norco is not medically necessary.