

<b>Case Number:</b>	CM15-0187187		
<b>Date Assigned:</b>	10/20/2015	<b>Date of Injury:</b>	12/27/2004
<b>Decision Date:</b>	12/01/2015	<b>UR Denial Date:</b>	09/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2015

### 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: Arizona, California

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:

This is a 44 year old male who sustained a work-related injury on 12-27-04. Medical record documentation on 8-10-15 and 5-12-15 revealed the injured worker was being treated for left lumbar radiculopathy. The injured worker was status post lumbar fusion on 10-23-08 at L4-S1 and fusion of L3-4 on 3-4-09. He reported low back pain with radiation of pain to the left leg. Objective findings included a mildly antalgic straight leg gait. He had moderate muscle spasm of the lumbar spine with the left side greater than the right side. His lumbar spine range of motion included flexion to 80% of normal, extension to 70% of normal, right lateral flexion to 80% of normal, and left lateral flexion to 70% of normal (8-10-15 and 5-12-15). He had a positive straight leg raise on the left at 80 degrees (8-10-15 and 5-12-15). His medication regimen included Norco 10-325 mg (since at least 5-12-15) and Ibuprofen 800 mg. A request for Norco 10-325 mg #30 was received on 9-10-15. On 9-15-15, the Utilization Review physician determined Norco 10-325 mg #30 was not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #30:** 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 for chronic pain, Opioids for neuropathic pain.

**Decision rationale:** Norco is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long-term use has not been supported by any trials. In this case, the claimant had been on Norco for over 2 years. The claimant is only using 1-2 per week. In addition, there is no indication that Tylenol cannot provide the same benefit. The continued use of Norco with 30 tablets per months is excessive and unnecessary. Therefore, the request is not medically necessary.