

Case Number:	CM15-0206830		
Date Assigned:	10/23/2015	Date of Injury:	07/18/2013
Decision Date:	12/07/2015	UR Denial Date:	10/14/2015
Priority:	Standard	Application Received:	10/20/2015

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: Massachusetts

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

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 59 year old male who sustained an industrial injury July 18, 2013. According to a primary treating physician's progress report dated September 28, 2015, the injured worker presented for evaluation of his ongoing neck and back pain. The physician documented he is struggling and was wheeled in, in an office chair. He started on Hysingla (noted first prescribed in office visit August 3, 2015) and began having nausea and vomiting blood, he hasn't eaten for 3 days until this morning and had a tortilla and took another Hysingla. He complains of constipation and does not have outside insurance to pay for medication. Current medication Hysingla (stopped 09-28-2015), Colace, and Norco (started 09-28-2015). Objective findings included; somewhat disoriented, elevated blood pressure 179-123 and pulse 139 and unable to repeat simple instruction or walk without assistance. He is unable to put any weight on his left leg, significant effusion and warmth to left knee. Diagnoses neck pain (MRI March 2014 mild bilateral foraminal stenosis C5-C6 with broad-based disc bulge; posterior disk protrusion as well C5-C6; thoracic spine pain; low back pain (CT November 2013 compression fracture T12 with 75% height loss and endplate fracture L2 with 35% loss of height and healing fracture left posterior 12th rib); left knee pain with effusion (non-industrial). Treatment plan included discontinuing Hysingla and arranging primary care for elevated blood pressure. At issue is the request for authorization for Norco. A toxicology report dated August 4, 2015 and present in the medical record revealed inconsistent results; unexpected negatives, may not be taking prescribed medication; Hydrocodone. According to utilization review dated October 14, 2015, the request for Norco 10-325mg #120 is non-certified. The request for Colace 100mg #120 is certified.

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 #120: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain, Opioids, dosing, Opioids, long-term assessment.

Decision rationale: The claimant sustained a work injury in July 2013 when he was struck by falling metal supports and is being treated for neck and low back pain. In August 2015 medications were decreasing pain from 10/10 to 5/10. He was taking Norco up to 6 times per day. Hysingla was requested and was authorized on 07/21/15. The total MED (morphine equivalent dose) was 40 mg per day. When seen in September 2015, he had nausea and vomiting after taking the Hysingla. He was really struggling and unable to walk into the examination room. He had an elevated blood pressure and pulse rate. Physical examination findings included being unable to walk without assistance. He was unable to repeat simple instructions. He was unable to bear weight on the left knee and there was significant warmth and an effusion. The claimant was redirected to the hospital for further evaluation. Norco was restarted at 10/325 mg #120. Norco (hydrocodone/acetaminophen) is a short acting combination opioid medication used for intermittent or breakthrough pain. In this case, it was being prescribed when the claimant was having severe pain and this medication had previously provided good pain control. There were no identified issues of abuse or addiction and the total MED prescribed remained less than 120 mg per day consistent with guideline recommendations. Prescribing was medically necessary.