

Case Number:	CM14-0117446		
Date Assigned:	08/06/2014	Date of Injury:	12/10/2009
Decision Date:	10/15/2014	UR Denial Date:	07/18/2014
Priority:	Standard	Application Received:	07/26/2014

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 Family 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:

This is a 61-year-old female with a 12/10/09 date of injury, when she was walking down the stairs and felt severe cramping in the right leg. The patient was seen on 5/21/14 for the orthopedic evaluation. Exam findings of the right lower extremity revealed mild tenderness over the trochanteric bursa, full range of motion of the hip with no instability and negative FABER test. The right knee range of motion was 0-130 degrees with painful patellofemoral crepitus with no patellar instability. The Lachman test, anterior drawer test and posterior drawer test were negative and varus and valgus stress tests were 0 and 30 degrees. The motor strength in quadriceps and hamstring was 5/5. McMurray test was negative. The sensation was decreased in the right L4 and L5 distribution and deep tendon reflexes were 2+ and symmetric bilaterally. The urine drug screen test dated 6/5/14 revealed inconsistency with opioid medications. The diagnosis is lumbar strain, right knee chondromalacia, carpal tunnel syndrome, and hip trochanteric bursitis. Treatment to date: knee brace, cane, medications, physical therapy, chiropractic therapy, injections, acupuncture and work restrictions. An adverse determination was received on 7/18/14 given that the submitted documentation did not provide evidence of significant functional deficits to the right knee/leg to warrant the need for pain medication. In addition, the documentation did not provide evidence of pain relief or functional improvement and the drug screen test dated 6/5/14 was inconsistent.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIATES
Page(s): 78-81.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Given the 2009 date of injury, the duration of opiate use to date is not clear. There is no discussion regarding non-opiate means of pain control, or endpoints of treatment. The records do not clearly reflect continued analgesia, continued functional benefit, a lack of adverse side effects, or aberrant behavior. The orthopedic evaluation dated 5/21/14 did not reveal that the patient suffered from the right knee pain that would require an opioid medication. In addition, the urine drug screen test dated 6/5/14 was inconsistent. Therefore, the request for Norco 10/325 # 90 was not medically necessary.