

Case Number:	CM14-0147494		
Date Assigned:	09/15/2014	Date of Injury:	08/25/2004
Decision Date:	10/15/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	09/11/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain 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:

The injured worker is a 56-year-old male who reported an injury on 08/25/2004. The mechanism of injury was not submitted for clinical review. Diagnoses included spinal/lumbar degenerative disc disease, thoracic/lumbar sacral neuritis or radiculitis, and postlaminectomy syndrome of thoracic region. The previous treatments included medication and lumbar epidural steroid injections. The clinical note dated 08/06/2014 reported the injured worker complained of lower back pain. He reported the pain radiated into both legs. The injured worker rated his pain 3/10 in severity with medication and 8/10 in severity without medication. On the physical examination, the provider noted the range of motion was restricted in the lumbar spine with flexion limited to 90 degrees and extension limited to 20 degrees. The paravertebral muscles had muscle spasms and tenderness on both sides. There was positive lumbar facet loading on both sides. A positive straight leg raise bilaterally. The provider requested Norco; however, a rationale was not submitted for clinical review. The request for authorization was submitted and dated on 08/12/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #90 With 3 Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, On-Going Management Page(s): 78.

Decision rationale: The request for Norco 10/325mg #90 with 3 refills is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The provider did not document an adequate and complete pain assessment within the documentation. The documentation did not indicate the medication had been providing objective functional benefit and improvement. Additionally, the use of a urine drug screen had not been submitted for clinical review. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.