

<b>Case Number:</b>	CM14-0181402		
<b>Date Assigned:</b>	11/06/2014	<b>Date of Injury:</b>	11/18/1999
<b>Decision Date:</b>	12/09/2014	<b>UR Denial Date:</b>	10/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2014

### 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 Emergency Medicine and is licensed to practice in Texas. 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 52-year-old female who reported an injury on 11/18/1999. The mechanism of injury was not submitted for clinical review. The diagnoses included postlaminectomy syndrome, lumbar spine radiculitis, status post Intrathecal pump implant, and sleep apnea. The previous treatments included medication, surgery. Within the clinical note dated 08/21/2014, it was reported the injured worker complained of pain rated 3/10 in severity. The injured worker complained of constant right hip and leg pain. Complained of swelling in the right thigh daily. The injured worker complained of increased throbbing and spasms in the bilateral legs. The injured worker complained of pain in the left side of the low back into the bilateral hips. Upon physical examination, the provider noted the lumbar spine range of motion was restricted in flexion at 0 degrees, extension of 5 degrees. The provider requested Norco. However, a rationale was not submitted for clinical review. The Request for Authorization was submitted and dated 10/02/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325 mg, QTY: 120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 77-78.

**Decision rationale:** The request for Norco 10/325 mg, QTY: 120 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. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The provider failed to document an adequate and complete pain assessment within the documentation. Additionally, the use of a urine drug screen was not submitted for clinical review. The requested submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.