MAXIMUS Federal Services

Case Number:	CM14-0094775		
Date Assigned:	09/22/2014	Date of Injury:	06/05/2009
Decision Date:	10/23/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	06/23/2014

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 Occupational 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 53-year-old male who sustained an injury on June 5, 2009. He is diagnosed with (a) status post open reduction and internal fixation of the right tibial plateau fracture; (b) status post hardware removal and right knee arthroscopy; (c) status post left thumb fracture, healed; (d) left index partial amputation; (e) facet arthropathy L3-S1 bilaterally; (f) degenerative disc disease L2-S1 with space narrowing; (g) right greater trochanter bursitis; (h) status post right total hip replacement done on January 6, 2014; and (i) status post right knee replacement; and (j) status post right hip arthroscopic decompression and labral resection dated December 17, 2012.He was seen on October 2, 2014 for an evaluation. He had complaints of low back pain with radiation to the right anterior thigh, which was rated 8/10, right hip pain, which was rated 7/10, and right knee pain, which was rated 9/10. Examination of the lumbar spine revealed tenderness over the paravertebral muscles bilaterally. Restricted sensation was noted on the right L4 dermatome. Range of motion was limited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids,Opioids, long-term assessment, Opioids, specific drug list Page(s): 76-80,88-89,91.

Decision rationale: The request for Norco 10/325 mg #180 is not medically necessary at this time. Guidelines state that to warrant continued use of opioid medications, the injured worker should have returned to work and/or there is evidence of improved pain and functioning. The injured worker has satisfied neither of these conditions for the past six months that he has been taking Norco. Hence, the request for Norco 10/325 mg #180 is not medically necessary.