

Case Number:	CM15-0010890		
Date Assigned:	01/28/2015	Date of Injury:	05/05/2011
Decision Date:	03/18/2015	UR Denial Date:	12/30/2014
Priority:	Standard	Application Received:	01/20/2015

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: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 46 year old male who sustained a work related injury May 5, 2011. Past history included hypertension. According to a primary treating physician's progress report dated December 18, 2014, the injured worker presented with chronic low back pain with radiation down to his bilateral legs and groin, 6/10 with medication. Physical examination reveals the gait is antalgic and slow, severe tenderness and tightness across the bilateral lumbosacral area with positive standard leg raise. There is continued dyesthesia and hypoaesthesia of bilateral posterior legs noted. Diagnoses included lumbago; degeneration of thoracic and lumbar intervertebral disc; thoracic or lumbosacral neuritis or radiculitis, unspecified; chronic pain syndrome; spasm of muscle; and depressive disorder. Electromyogram and nerve conduction velocity study (14 Feb 2012) showed L5 radiculopathy. Treatment plan included conservative measures with continued use of heat, ice, rest, and gentle stretching and exercise, and medications (Lyrica, oxycodone 15mg three times/day, Zanaflex, and lisinopril). According to utilization review dated December 30, 2014, the request for Prilosec was authorized. The request for Norco 10/325mg #120 was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #120 prescribed on 12/18/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-9, Chronic Pain Treatment Guidelines Opioids Page(s): 60, 74-96.

Decision rationale: Hydrocodone-Acetaminophen (Norco) is a mixed medication made up of the short acting, opioid, hydrocodone, and acetaminophen, better known as Tylenol. It is recommended for moderate to moderately severe pain with usual dosing of 5-10 mg hydrocodone per 325 mg of acetaminophen taken as 1-2 tablets every 4-6 hours. Maximum dose according to the MTUS is limited to 4 gm of acetaminophen per day, which is usually 120 mg/day of hydrocodone. According to the MTUS opioid therapy for control of chronic pain, while not considered first line therapy, is considered a viable alternative when other modalities have been tried and failed. If treating chronic low back pain, opioids effectiveness is limited to short-term pain relief (up to 16 weeks) as there is no evidence of long-term effectiveness. It is known that long-term use of opioids is associated with hyperalgesia and tolerance. According to the MTUS, opioid therapy for control of chronic pain, while not considered first line therapy, is considered a viable alternative when other modalities have been tried and failed. Success of this therapy is noted when there is significant improvement in pain or function. The risk with this therapy is the development of addiction, overdose and death. The pain guidelines in the MTUS directly address this issue and have outlined criteria for monitoring patients to prevent iatrogenic morbidity and mortality. The provider is not following these safe use recommendations in that there has been no evaluations by documented patient interview or by urine drug testing to screen for drug abuse or drug-seeking behaviors. Additionally, the patient's daily dose of short-acting oxycodone is documented to be controlling the patient's pain so the addition of more short-acting opioids doesn't make sense. Medical necessity for use of this medication has not been established.