

Case Number:	CM15-0014364		
Date Assigned:	02/02/2015	Date of Injury:	02/12/2003
Decision Date:	03/30/2015	UR Denial Date:	01/06/2015
Priority:	Standard	Application Received:	01/26/2015

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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 reported an injury on 02/12/2003 due to an unspecified mechanism of injury. On 12/18/2014, he presented for a followup evaluation regarding his work related injury. He reported back pain that radiated into the right leg with a heavy numbing sensation and burning pain rated at a 9/10 to 10/10, at its best a 4/10 with medications and 10/10 without. He reported a 50% reduction in pain, 50% functional improvement with activities of daily living with the medications. He also reported ongoing left shoulder pain rated at a 6/10 and left knee pain rated at a 6/10. A physical examination showed limited range of motion and right and left straight leg raises causing left sided back pain that radiated into the left buttock and posterior thigh. He reported sensation loss to light touch and pinprick in the left lateral calf and bottom of his foot. He ambulated with a limp and deep tendon reflexes remained at a +1 at the knees and ankles. Toes were downgoing to plantar reflexes bilaterally. The left shoulder examination showed limited range of motion with a positive impingement sign and crepitus on circumduction. The left knee revealed a negative McMurray's sign, patellar compression was painful and apprehension was negative. There was swelling around the parapatellar region of the knee not seen on the right counterpart. He was diagnosed with low back pain with right radicular symptoms, MRI revealing an L5-S1 disc herniation impinging on the right L5 exiting nerve root, left shoulder decompression with myofascial pain and left knee pain with chondromalacia of the patella. His medications included Norco 10/325 mg one 3 times a day as needed, ibuprofen 800 mg 3 times a day and Flexeril 10 mg every 6

hours as needed for back spasms. The treatment plan was for Norco 10/325 mg #90. The rationale for treatment was to treat the injured worker's symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone / Acetaminophen (Norco), Opioids, Criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-going Management Page(s): 78.

Decision rationale: The California MTUS Guidelines indicate that an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should be performed during opioid therapy. Based on the clinical documentation submitted for review, the injured worker was noted to be getting pain relief with the use of his medications. However, no official urine drug screen or CURES reports were provided for review to validate that he has been compliant with his medication regimen and support ongoing medication use. Furthermore, the frequency of the medication was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.