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| Case Number: | CM15-0016289 | | |
| Date Assigned: | 02/04/2015 | Date of Injury: | 10/19/2010 |
| Decision Date: | 03/23/2015 | UR Denial Date: | 12/29/2014 |
| Priority: | Standard | Application Received: | 01/28/2015 |

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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

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 41 year old male, who sustained an industrial injury on 10/19/2010. The diagnoses have included right ilioinguinal, iliohypogastric and/or genitofemoral neuralgia. Noted treatments to date have included surgery, physical therapy, home exercise program, spinal cord stimulator, and medications. Diagnostics to date have included urine drug screen on 10/16/2014 which was noted as being consistent with taking Hydrocodone/APAP (acetaminophen). In a progress note dated 12/16/2014, the injured worker presented with complaints of right testicular pain. The treating physician reported the medications prescribed are medically necessary as they provide analgesia, help the injured worker to better perform valued activities of daily living, and improve affect and overall quality of life without any intolerable side effects. Utilization Review determination on 12/29/2014 non-certified the request for Norco 10/325mg #90 citing Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines.

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 Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 74-96.

Decision rationale: MTUS does not discourage use of opioids past 2 weeks, but does state that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The treating physician does not fully document the least reported pain over the period since last assessment, pain relief, or improved quality of life. Additionally, medical documents indicate that the patient has been on Norco since 9/2010, in excess of the recommended 2-week limit. As such, the request for Norco 10/325 mg #90 is not medically necessary.