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| Case Number: | CM13-0051746 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 04/28/2010 |
| Decision Date: | 06/23/2014 | UR Denial Date: | 10/14/2013 |
| Priority: | Standard | Application Received: | 11/14/2013 |

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain 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 57 year old female who reported an injury on 04/28/2010. The worker was injured by a fall injury to her right wrist and forearm while working as bus maintenance. The injured worker is diagnosed with cervical spine sprain and strain with spondylosis and disc degenerative disease, thoracolumbar sprain and strain with disc degenerative disease and facet joint osteoarthritis, bilateral shoulder sprain and strain with tendinopathy, and bilateral knee patellofemoral arthralgia and osteoarthritis. The most recent examination on 11/01/2013 the injured worker stated her symptoms were unchanged. She reported that her medications were helping her to walk in exercising with care, to walk on treadmill daily, and to help with sleep disruptions secondary to pain and muscle spasms. The pain scale was rated 7/10 with medications and 5/10 with medications. The request of authorization form was submitted 09/23/2013 for Norco 10/325mg #120 1 by mouth every 6 hours for pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for osteoarthritis Page(s): 83.

Decision rationale: The request for Norco 10/325 is not medically necessary. The injured worker has multiple diagnoses including osteoarthritis. The California Chronic Pain Medical Treatment guidelines do not recommend opioids as a first-line therapy for osteoarthritis. The guidelines recommend opioids on a trial basis for short-term use after there has been evidence of failure of first-line non-pharmacologic and medication options (such as acetaminophen or NSAIDS) and when there is evidence of moderate to severe pain. There was a lack of evidence any other treatments have been attempted and no progressive functional improvement documentation. Therefore, the request is not medically necessary.