

<b>Case Number:</b>	CM14-0174048		
<b>Date Assigned:</b>	10/27/2014	<b>Date of Injury:</b>	08/11/2011
<b>Decision Date:</b>	12/04/2014	<b>UR Denial Date:</b>	10/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/22/2014

### 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 Physical Medicine and Rehabilitation 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 53-year-old female who reported an injury on 08/11/2011 due to an unknown mechanism. Diagnoses were impingement syndrome of the left shoulder, status post arthroscopic decompression, internal derangement of the right knee joint, status post arthroscopic meniscectomy, and severe post-traumatic osteoarthritis in the right knee. Physical examination on 10/08/2014 revealed continued complaints of bilateral knee pain that was rated a 9/10 on the pain scale. The injured worker reported difficulty with prolonged standing, sitting, and laying. She reported difficulty with ascending and descending a flight of stairs. The previous Synvisc injection to her right knee provided relief for about 1 month. However, the injured worker reported her symptoms were getting worse. Examination of the left shoulder revealed no gross deformity, no masses, and no swelling. There were no signs or symptoms of infection or cutaneous abnormalities. There was still tenderness on palpation over the anterior lateral aspect of the deltoid. The injured worker displayed full range of motion. There was decreased strength 4/5 with abduction and forward flexion. Treatment plan was to continue at home exercise and a weight loss program to help improve prognosis. Also, she was to continue with medications as directed. The rationale and Request for Authorization were not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One prescription of Tylenol No. 3 #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid, Pure Agonist; Ongoing Management; Codeine; Criteria for Use of Opioids Page(s): 74; 78;.

**Decision rationale:** The decision for one prescription of Tylenol No. 3 #60 is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Guidelines indicate that Tylenol with codeine 3 should be used for moderate to severe pain and there should be documentation of the 4 A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior. The medical guidelines criteria for long term users of an opioid medication are: document pain and functional improvement and compare to baseline; satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The 4 A's for ongoing management of an opioid medication were not reported. Also, the injured worker reported her pain as a 9/10. Failure to respond to a time limited course of opioids should lead to the suggestion of reassessment and consideration of alternative therapy. The injured worker is reporting no pain relief from the use of this medication. Alternative pain methods should be considered. Furthermore, the request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.