

<b>Case Number:</b>	CM14-0060467		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	09/11/2008
<b>Decision Date:</b>	09/15/2014	<b>UR Denial Date:</b>	04/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/01/2014

### 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 Internal Medicine and is licensed to practice in California. 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:

This is a 59-year-old female with a 9/11/08 date of injury. The mechanism of injury was not noted. According to a progress report dated 3/13/14, the patient felt that her pain has improved 50% to 60% from her right shoulder surgery. The patient has completed physical therapy in terms of the right shoulder. She stated that she is having difficulty with localized back discomfort. Objective findings: tenderness on the anterior and lateral aspect of the right shoulder, well-healed scars noted about the right shoulder, Tinel's and Phalen's are negative at the right wrist. Diagnostic impression: left greater than right shoulder pain, status post right shoulder arthroscopic surgery on 10/29/13, low back pain. Treatment to date: medication management, activity modification, physical therapy, surgery. A UR decision dated 4/23/14 denied the retrospective requests for Norco 5/325 mg, Gabapentin, and Norco 10/325 mg. A specific rationale for denial was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective DOS: 3/13/14: Norco 5/325mg, #60: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 78-81.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There is documentation that the patient has pain relief and improved activities of daily living from her medication use; however, there is no discussion that this is specifically from Norco. In addition, it is noted that the patient's urine drug screen did not reveal any inconsistencies; however, the report itself was not provided for review. Furthermore, the patient is also utilizing Norco 10/325 mg. Guidelines do not support the use of multiple opioid medications containing the same ingredients in a different strength. Therefore, the request for Retrospective DOS: 3/13/14: Norco 5/325mg, #60 is not medically necessary.

**Retrospective DOS: 3/13/14: Gabapentin #180:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 16-18, 49. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA (Neurontin).

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines states that Gabapentin has been shown to be effective for the treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. There is no documentation in the reports reviewed that there is a neuropathic component to the patient's pain. It is unclear why gabapentin has been prescribed for this patient. Therefore, the request for Retrospective DOS: 3/13/14: Gabapentin #180 is not medically necessary.

**Retrospective DOS: 3/13/14: Norco 10/325mg, #120:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 78-81.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There is documentation that the patient has pain relief and improved activities of daily living from her medication use; however, there is no discussion that this is specifically from Norco. In addition, it is noted that the patient's urine drug screen did not reveal any inconsistencies; however, the report itself was not provided for review. Furthermore, the patient is also utilizing Norco 5/325 mg. Guidelines do not support the use of multiple opioid medications containing

the same ingredients in a different strength. Therefore, the request for Retrospective DOS:  
3/13/14: Norco 10/325mg, #120 is not medically necessary.