

<b>Case Number:</b>	CM14-0063783		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	01/06/2014
<b>Decision Date:</b>	08/22/2014	<b>UR Denial Date:</b>	04/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/06/2014

### 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 Anesthesiology, 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 45 year old female injured on 01/06/14 while twisting and pulling on linens. Prior treatment included nine sessions of physical therapy. Current diagnoses included chondromalacia of patella, lateral epicondylitis of elbow, lumbar sprain and strain, tenosynovitis of hand and wrist, rotator cuff syndrome of shoulder, sprain and strain of shoulder and upper arm, and thoracic/lumbosacral neuritis/radiculitis. The injured worker reported bilateral upper extremity pain with paresthesia into the hands rated 8/10 relieve by Flexeril, Norco, and Tylenol. Objective findings included lumbar decreased range of motion, deep tendon reflexes L4 less on the right, sensation within normal limits, straight leg raise positive on the right, bilateral shoulder decreased range of motion, right knee decreased range of motion, swelling 10% over normal, 2+/5 tenderness to palpation over lateral medial joint line, McMurray negative. The initial request for Norco 5-325mg #61 by mouth every 12 hours as needed, ultrasound bilateral shoulders and right knee was non-certified on 04/28/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 5/325 mg #60 1 by mouth every 12 hours as needed:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80-81 and 91- 92 of 127.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

**Decision rationale:** As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Specific examples of improved functionality should be provided to include individual activities of daily living, community activities, and exercise able to perform as a result of medication use. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Norco 5/325 mg #60 1 by mouth every 12 hours as needed cannot be established at this time.

**Ultrasound bilateral shoulders:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder (Acute and Chronic), Ultrasound, diagnostic.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines online version, Shoulder complaints, Ultrasound (Diagnostic).

**Decision rationale:** As noted in the current CAMTUS, ultrasonography is not recommended for evaluation of the rotator cuff. Additionally, there is no discussion in recent clinical documentation regarding the medical necessity of shoulder ultrasound or clinical indications/implications. As such, the request for Ultrasound bilateral shoulders cannot be recommended as medically necessary at this time.

**Ultrasound of the right knee:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee and Leg (Acute and Chronic), Ultrasound, Diagnostic.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines online version, Knee Disorders, Ultrasound (Diagnostic).

**Decision rationale:** As noted in the current CAMTUS, there is no recommendation for or against the use of ultrasound for evaluating other knee disorders, including osteonecrosis, osteoarthritis, dysplasia, or fractures. Additionally, there is no discussion in recent clinical documentation regarding the medical necessity of shoulder ultrasound or clinical indications/implications. As such, the request for Ultrasound of the right knee cannot be recommended as medically necessary at this time.