

<b>Case Number:</b>	CM14-0097683		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	06/19/2011
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	06/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/20/2014

### 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 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:

The injured worker is a 52-year-old female who reported an injury on 06/19/2011. The mechanism of injury was not provided for clinical review. The diagnoses included left knee pain, right shoulder and upper extremity pain, neck pain, and chronic right shoulder pain. The previous treatments included medication and a Functional Capacity Evaluation. Diagnostic imaging included a CT scan and an MRI. Within the clinical note dated 05/27/2014, it was reported the injured worker stated her pain was doing fairly well and controlled with medication. The injured worker rated her pain 4/10 to 5/10 in severity with medication, and a 9/10 in severity without medication. Upon the physical examination, the provider noted the right upper extremity was red, shiny, and atrophic. The provider noted tenderness to the left knee. The injured worker had slight decreased strength to the right quadriceps. The provider requested Norco. However, a rationale was not provided for clinical review. The Request for Authorization was not provided for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10-325mg #480 Retro 5/27/14:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78..

**Decision rationale:** The request for Norco 10-325mg #480 Retro 5/27/14 is non-certified. The injured worker reported her pain levels had been fairly well controlled with medication. She rated her pain 4/10 to 5/10 in severity with medication, and a 9/10 in severity without medication. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The provider failed to document an adequate and complete physical pain assessment within the documentation. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The injured worker has been utilizing the medication since at least 01/2014. The request submitted failed to provide the frequency of the medication. Therefore, the request is non-certified.