MAXIMUS Federal Services

| Case Number: | CM15-0104236 | | |
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| Date Assigned: | 06/08/2015 | Date of Injury: | 12/28/2008 |
| Decision Date: | 07/14/2015 | UR Denial Date: | 05/22/2015 |
| Priority: | Standard | Application Received: | 06/01/2015 |

## 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California, Hawaii
Certification(s)/Specialty: Physical Medicine & Rehabilitation

## 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 46-year-old female, who sustained an industrial injury on 12/28/2008. Diagnoses have included intractable pain in left arm, left shoulder and neck most likely due to left brachial plexus injury, chronic, cervical myofascial pain syndrome and major depression. Treatment to date has included shoulder surgery and medication. According to the progress report dated 4/15/2015, the injured worker complained of frequent pain and numbness in her left arm, as well as constant pain in her left shoulder, neck and upper back that ranged from 6-8/10 without medications. She stated she had gotten greater than 60-70% improvement in her both overall pain and functional ability with her current medications, which decreased her pain to 2/10. Physical exam revealed slightly too moderately restricted cervical and thoracic range of motion. There were multiple myofascial trigger points and taut bands noted. Range of motion of the left shoulder was moderately decreased in all directions. There was mild winging of the left scapular noted. Sensation to fine touch and pinprick was decreased in the left arm and left hand. The injured worker was not currently working. Authorization was requested for Norco.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg 150.00:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opoids Page(s): 74-96.

**Decision rationale:** The patient presents with frequent pain and numbness in the left arm, as well as constant pain in the left shoulder, back, and upper back than ranged from 6-8/10 without medications. The current request is for Norco 10/325mg 150. The treating physician states, in a report dated 04/15/15, "Norco 10/325 mg 1tab every 4-6 hours = #150 for 6 weeks with no refill." (69B) The MTUS guidelines state, "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. Information from family members or other caregivers should be considered in determining the patient's response to treatment. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS also requires documentation of the four A's (analgesia, ADL's, Adverse effects and Adverse behavior). In this case, the treating physician, based on the records available for review, states, "With regards to Norco 10/325mg recommended above, as per MTUS guidelines, please note the following: Significant intolerable side-effects to the prescribed medication(s) are not seen in this patient. The patient has greater than 60-70% relief of pain with the prescribed medication using a VAS where pain is 8/10 w/o meds and decreases to 2/10 with current medications. The patient's ability to function is significantly improved with the medication as the patient is able to perform activities of daily living more than 60-70% of the time, such as sitting, standing, walking, bathing, cooking, sleeping and socializing. There is no documented abuse, diversion, or hoarding of the prescribed medication and there is no evidence of illicit drug use. Urine drug screen is done on a periodic basis to monitor compliance with treatment regimen." The physician documentation satisfies MTUS guidelines. The current request is medically necessary.