

Case Number:	CM15-0138723		
Date Assigned:	07/28/2015	Date of Injury:	11/01/2012
Decision Date:	08/26/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	07/17/2015

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

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 male, who sustained an industrial injury on November 1, 2012. He reported severe pain in his right shoulder. The injured worker was diagnosed as having right shoulder adhesive capsulitis, impingement syndrome of the right shoulder with tendinosis and partial rotator cuff tear. Treatment to date has included diagnostic studies, surgery, physical therapy, cortisone injection, chiropractic treatment, medications and exercise. Physical therapy was noted to not be helpful. Currently, the injured worker complained of moderate right shoulder pain. Physical examination of the right shoulder revealed tenderness to palpation of the acromioclavicular joint, anterior shoulder, lateral shoulder and posterior shoulder. The treatment plan included chiropractic physiotherapy two times a week for three weeks for the right shoulder. On June 16, 2015, Utilization Review non-certified the request for Norco 10/325 mg #90, citing California MTUS Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen, Opioids, Criteria for Use, Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-94.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of Norco, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 8 months. Norco 10/325mg #90 is not medically necessary.