

Case Number:	CM15-0201419		
Date Assigned:	10/16/2015	Date of Injury:	04/13/2003
Decision Date:	11/24/2015	UR Denial Date:	09/15/2015
Priority:	Standard	Application Received:	10/13/2015

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, Oregon, Washington
Certification(s)/Specialty: Orthopedic Surgery

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 63 year old female, who sustained an industrial injury on 4-13-03. Medical records indicate that the injured worker is undergoing treatment for chronic intractable right knee pain, chronic left knee pain, chronic left shoulder pain, chronic myofascial pain with cervical spinal stenosis, chronic low back pain and chronic thoracic myofascial pain. The injured worker is not currently working. On (8-12-15 and 7-31-15) the injured worker complained of bilateral shoulder pain, bilateral knee pain and low back pain. The injured worker noted a flare- up of right shoulder pain after an MRI scan. Objective findings revealed tenderness and swelling of the knees, more tenderness on the right than the left. Bilateral shoulder examination revealed rotator cuff tenderness with supraspinatus and infraspinatus tenderness bilaterally. Bilateral shoulder range of motion was decreased. Cervical, thoracic and lumbar spine tenderness was noted, as well as sacroiliac joint and trochanteric tenderness. Spasm was noted in the lower thoracic and lumbar spine. Pain levels were not provided. The injured worker was noted to have difficulty walking and used a wheelchair. Treatment and evaluation to date has included medications, MRI of the bilateral shoulders and a left rotator cuff repair. Current medications include Norco (since at least March of 2015). The current treatment request is for Norco 10-325 mg # 180. The Utilization Review documentation dated 9-15-15 modified the request to Norco 10-325 mg #30 (original request # 180).

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, specific drug list.

Decision rationale: According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids, a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Opioids may be continued if the patient has returned to work and the patient has improved functioning and pain. Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The ODG-TWC pain section comments specifically on criteria for the use of drug screening for ongoing opioid treatment. Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. There is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity from the exam note of 8/12/15 and 7/31/15. Therefore the determination is not medically necessary.