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| Case Number: | CM15-0023074 | | |
| Date Assigned: | 02/12/2015 | Date of Injury: | 02/12/2001 |
| Decision Date: | 04/07/2015 | UR Denial Date: | 01/13/2015 |
| Priority: | Standard | Application Received: | 02/06/2015 |

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, Arizona
 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 49-year-old female who reported an injury on 02/12/2001 due to an unspecified mechanism of injury. On 02/13/2015, she presented for a follow-up evaluation regarding her work related injury. It was noted that she was status post right shoulder arthroscopy with subacromial decompression, excision of the distal clavicle, and open biceps tenodesis with SLAP lesion debridement and rotator cuff repair on 01/13/2015. She stated that she had been relatively comfortable in her sling, but was noting some pain and discomfort about the left arm, neck, and shoulder region. A physical examination showed that her postoperative wounds were healing well without evidence of infection and sensation was intact. Her medications included Percocet 5/325 mg 1 to 2 every 4 to 6 hours as needed for pain, and hydrocodone/acetaminophen 10/325 mg 1 to 2 tabs every 4 to 6 hours as needed for pain. The treatment plan was for Norco to alleviate the injured worker's symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

Decision rationale: The California MTUS Guidelines indicate that an ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be performed during opioid therapy. The documentation provided does not show that the injured worker is having a quantitative decrease in pain or an objective improvement in function with the use of this medication to support its continuation. Also, no official urine drug screens or CURES reports were provided for review to validate compliance with the medication regimen. Furthermore, the frequency of the medication was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.