

<b>Case Number:</b>	CM15-0030295		
<b>Date Assigned:</b>	02/23/2015	<b>Date of Injury:</b>	05/07/1999
<b>Decision Date:</b>	04/01/2015	<b>UR Denial Date:</b>	01/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/18/2015

### 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: Emergency 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 male, who sustained an industrial injury on 05/07/1999. On provider visit dated 01/19/2015 the injured worker has reported right knee, bilateral carpal tunnel, left shoulder pain and low back pain. The diagnoses have included lumbar spondylosis status post L4-L5 and L5 -S1 laminectomies and status post left knee medical unicompartmental arthroplasty and status post 16 surgeries on right knee. Treatment to date has included medication and the use of a motorized scooter. On examination he was noted to have decreased motor strength on right hip flexion and knee extension, right knee swelling, and diffuse tenderness. Treatment plan included current medication regimen, and motorized electric wheelchair. On 01/25/2015 Utilization Review non-certified Prescription of Norco 10/325mg #120 and Motorized Scooter. The CA MTUS, ACOEM, Chronic Pain Medical Treatment Guidelines and ODG were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prescription of Norco 10/325mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82 Page(s): 78-82.

**Decision rationale:** The requested Prescription of Norco 10/325mg #120, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has right knee, bilateral carpal tunnel, left shoulder pain and low back pain. The treating physician has documented decreased motor strength on right hip flexion and knee extension, right knee swelling, and diffuse tenderness. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract or urine drug screening. The criteria noted above not having been met, Prescription of Norco 10/325mg #120 is not medically necessary.

**Motorized Scooter:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices Page(s): 99.

**Decision rationale:** The requested Motorized Scooter , is not medically necessary. Chronic Pain Treatment Guidelines 7/18/2009 PAGE NUM: 99 TREATMENT: Power mobility devices (PMDs): "Not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, if the patient has sufficient upper extremity function to propel a manual wheelchair, or if a caregiver is available, willing, and able to provide assistance with a manual wheelchair." The injured worker has right knee, bilateral carpal tunnel, left shoulder pain and low back pain. The treating physician has documented decreased motor strength on right hip flexion and knee extension, right knee swelling, and diffuse tenderness. There is not sufficient documentation contraindicating the use of a manual wheelchair. The criteria noted above not having been met, Motorized Scooter is not medically necessary.