

<b>Case Number:</b>	CM14-0133898		
<b>Date Assigned:</b>	08/25/2014	<b>Date of Injury:</b>	12/14/1995
<b>Decision Date:</b>	10/09/2014	<b>UR Denial Date:</b>	08/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2014

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 71-year-old male who reported an injury on 12/14/1995. The mechanism of injury was not provided for clinical review. The diagnoses status post right knee arthroscopy, total knee replacement, knee pain, left knee degenerative joint disease. The previous treatments included medication, surgery, and a transcutaneous electrical nerve stimulation (TENS) unit. Within the clinical note dated 07/22/2014, it was reported the injured worker complained of right and left knee pain. The injured worker described the pain as constant burning sensation in his legs. He rated his pain 9/10 in severity. The medication regimen included oxycodone, Norco, and Neurontin. Upon physical examination, the provider noted the injured worker's right knee revealed limited range of motion was flexion at 90 degrees and extension 0 degrees. The provider requested Norco for pain. The Request for Authorization was submitted on 07/25/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

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

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Long-term assessment: Norco:.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Page(s): 78.

**Decision rationale:** The request for Norco 10/325 mg #120 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The provider failed to document an adequate and complete pain assessment within his documentation. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. Additionally, the request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.