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| <b>Case Number:</b>   | CM14-0058958 |                              |            |
| <b>Date Assigned:</b> | 07/09/2014   | <b>Date of Injury:</b>       | 08/08/2000 |
| <b>Decision Date:</b> | 06/08/2015   | <b>UR Denial Date:</b>       | 04/25/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 04/29/2014 |

### 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. 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 62 year old female who sustained an industrial injury on 08/08/00. Initial complaints and diagnoses are not available. Treatments to date include medications and right shoulder surgery. Diagnostic studies are not addressed. Current complaints include bilateral shoulder pain. Current diagnoses include left shoulder capsulitis, cervical degenerative disc disease, and bilateral shoulder degenerative joint disease. In a progress note dated 04/02/14 the treating provider reports the plan of care as medications including Ambien, Norco, Extra Strength Tylenol, Dexilant, Senokot, Amitiza, Carisoprodol, Celebrex, and Intermezzo. The requested treatment is Norco.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325 mg #150 with 3 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management Page(s): 78-80.

**Decision rationale:** Norco 10/325 mg #150 with 3 refills is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that a satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. The documentation reveals that the patient has been on long term opioids without significant evidence of functional improvement therefore the request for continued Norco is not medically necessary.