

<b>Case Number:</b>	CM15-0073712		
<b>Date Assigned:</b>	04/23/2015	<b>Date of Injury:</b>	09/10/2001
<b>Decision Date:</b>	05/21/2015	<b>UR Denial Date:</b>	04/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/17/2015

### 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: 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 63 year old male, who sustained an industrial injury on September 10, 2001. He reported pain in the left shoulder and lumbar spine. The injured worker was diagnosed as having synovitis, bursitis of the shoulder, rotator cuff syndrome and displacement of intervertebral discs without myelopathy. Treatment to date has included diagnostic studies, conservative care, medications and work restrictions. Currently, the injured worker complains of shoulder pain, lumbar spine pain and right ankle pain. The injured worker reported an industrial injury in 2001, resulting in the above noted pain. He was treated conservatively without complete resolution of the pain. Evaluation on November 12, 2014, revealed continued pain as noted. Tylenol was requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tylenol No. #3 Qty 120 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308, table 12-8, Chronic Pain Treatment Guidelines Codeine Page(s): 35.

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

**Decision rationale:** Tylenol No. #3 Qty 120 with 1 refill is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS Chronic Pain Medical Treatment Guidelines state that a 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 guidelines state 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 does not indicate a clear pain assessment or significant functional improvement despite use of Tylenol #3. The request for Tylenol No. #3 Qty 120 with 1 refill is not medically necessary.