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| Case Number: | CM15-0095423 | | |
| Date Assigned: | 07/15/2015 | Date of Injury: | 04/13/2003 |
| Decision Date: | 08/10/2015 | UR Denial Date: | 04/18/2015 |
| Priority: | Standard | Application Received: | 05/18/2015 |

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: Arizona, California

Certification(s)/Specialty: Family Practice

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 (IW) is a 62 year old female who sustained an industrial injury on 04-13-2003. She reported a trip and fall accident in which she hurt both her shoulders, especially the left shoulder, her back, left hip, and left knee. The injured worker was diagnosed as having left rotator cuff tear, lumbar strain, with likely herniated nucleus pulposus with radicular signs of L5-S1 distribution, left sacroiliac strain, and PTSD. Treatment to date has included surgeries for torn rotator cuff in the left shoulder. Currently, the injured worker complains of bilateral knee pain, pain in the neck and bilateral shoulder pain and insomnia. There is tenderness and swelling in the right knee. There is decreased range of motion in all planes of the lumbar spine and decreased range of motion in the cervical spine. Paracervical tenderness is present in the cervical, thoracic, and lumbar spine. Her right shoulder abduction is 85 degrees. Extension is 10 degrees and flexion is 85. On the left shoulder, abduction is 30 degrees, extension is 5 degrees, and flexion is 10 degrees. There is tenderness throughout the right rotator cuff, supraspinatus and infraspinatus, with the same areas of tenderness mirrored in the right shoulder. Diagnoses as of 04-13-2015 include: 1. Diabetes (nonindustrial); 2. Chronic intractable right knee pain, status post total revision of a total knee arthroplasty with placement of a new prosthesis 03-07-2011. 3. Chronic left knee pain, status post partial knee replacement on 06-13-2011. 4. Chronic left shoulder pain, status post left shoulder surgery with residual adhesive capsulitis and evidence of rotator cuff tear with loss of range of motion and continued symptoms. 5. Chronic right shoulder pain due to a fall sustained in mid-January 2007, secondary to medication taken for the work-related injury of 04-13-2003 with current flare of her symptoms due to continued use of manual wheelchair, and use of a walking cane. 6. Chronic lumbar back pain with moderate to severe bilateral posterior facet arthropathy and osteophytes from the posterior facets encroaching into the neural foramen without myelopathy. Degenerative disc disease is present. 7. Morbid obesity

in part caused by immobility secondary to the injuries from 04-12-2003. Medications include Norco, which relieves pain without significant side effects. The worker has increased ability to perform activities of daily living with this medication. There is no evidence of aberrant behavior with the drug. The treatment plan includes diagnostic MRI of both shoulders, and continuation of medications and advocacy for a new electric scooter. A request for authorization is made for the following: 1. Norco 10/325 mg #180, 2. Electric scooter, 3. Diclofenac pump spray.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids, weaning of medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 82-92.

Decision rationale: Norco is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Norco for several years without significant improvement in pain or function. Pain scores are not routinely documented. The continued use of Norco is not medically necessary.

Electric scooter: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices Page(s): 99.

Decision rationale: According to the guidelines, powered mobility devices are generally not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. In this case, the claimant does have reduced range of motion of the shoulder and inability to walk or exercise due to knee surgery and pain. The claimant had a malfunctioning electric wheelchair and wishes to receive another. The request is appropriate and medically necessary.