

<b>Case Number:</b>	CM14-0146925		
<b>Date Assigned:</b>	09/15/2014	<b>Date of Injury:</b>	12/12/2003
<b>Decision Date:</b>	10/21/2014	<b>UR Denial Date:</b>	09/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/10/2014

### 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 and Rehabilitation, and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 62 year old male was reportedly injured on December 12, 2003. The most recent progress note, dated September 17, 2014, indicated that there were ongoing complaints of neck and low back pains, as well as left knee pain, jaw pain, shoulder stiffness and pain, and headaches. The physical examination of the shoulders exhibited a positive impingement sign bilaterally, as well as positive supraspinatus motor testing and cross adduction testing bilaterally, but was worse on the left side, slightly reduced range of motion in the right shoulder and moderately reduced range of motion in the left shoulder, particularly with abduction and forward flexion, demonstrated tenderness to palpation throughout the cervical and cervical paraspinal regions, spasm was noted in the bilateral cervical paraspinal regions and trapezius muscles, moderately reduced range of motion with rotation bilaterally, but otherwise range of motion was slightly reduced in all other planes, thoracic spine exhibited tenderness to palpation at the T3 to T5 levels, no paraspinal tenderness was noted in the thoracic spine, tenderness to palpation throughout the lumbar spine, with some slight left and slight to moderate right lumbar paraspinal tenderness noted, full range of motion with flexion and straight leg raise test was negative bilaterally, left knee exhibited medial and lateral joint line tenderness with some crepitus on active range of motion in both knees, and flexion was slightly decreased in both knees, tenderness to palpation along the medial aspect of the left ankle, plantar flexion in the left ankle was slightly reduced compared to the right, tenderness noted at the bilateral plantar fascia and with metatarsal compression bilaterally, left worse than right, deep tendon reflexes in the upper and lower extremities were normal and symmetric bilaterally, 5/5 motor testing in all major muscle groups of the upper and lower extremities. Diagnostic imaging studies were not included for review. Previous treatment regimens were not included for review. A request was

made for a prescription of Norco 5/325 milligrams, quantity 150 with one refill and was not certified in the preauthorization process on September 5, 2014.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Norco 5/325mg #150 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 177, 207, 303, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91.

**Decision rationale:** As noted in the MTUS, this is for the short term management of moderate to severe breakthrough pain. Furthermore, as outlined in the MTUS, the treatment plan parameters outlined in the MTUS for chronic opioid use require noting if the diagnosis has changed, or if other medications are being employed. While an attempt has been made to establish the efficacy of the medication and documentation of functional improvement is noted, the medication is only approved when used at the lowest possible dose with ongoing review and documentation of certain parameters, such as improved function, notation of a goal to return to work, etc. Furthermore, adverse effects have to be addressed. The clinician fails to not only specifically note functional improvement, but also whether any other nonnarcotic methods are being utilized. Therefore, none of these parameters to continue this medication chronically have been measured, and the medical necessity is not established.