

<b>Case Number:</b>	CM13-0036495		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	11/07/2001
<b>Decision Date:</b>	02/07/2014	<b>UR Denial Date:</b>	09/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Medicine, and is licensed to practice in Texas. 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 physician 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 patient is a 57-year-old female who reported an injury on 11/07/2001. The patient is currently diagnosed with cervical pain, cervical radiculopathy, cervical spondylosis, shoulder pain, and cervical disc degeneration. The patient was recently seen by [REDACTED] on 12/05/2013. The patient reported 8/10 pain with radiation to bilateral upper extremities. The patient also reported difficulty sleeping and no changes to activity limitations. Physical examination revealed restricted range of motion of the cervical spine, tenderness to the rhomboids and trapezius, restricted range of motion of the right shoulder, tenderness in the acromioclavicular joint and subdeltoid bursa, limited motor testing secondary to pain, and intact sensation. Treatment recommendations included continuation of current medications and home exercise program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Kadian 100mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessment should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite the ongoing use, the patient continues to report high levels of pain without any change in activity limitation. The patient also reports radiating pain and difficulty sleeping. Satisfactory response to treatment has not been indicated by a decrease in pain level, increase in function, or improved quality of life. Therefore, ongoing use cannot be determined as medically appropriate. As such, the request is non-certified.

**Roxicodone 156mg #168:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessment should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite the ongoing use, the patient continues to report high levels of pain without any change in activity limitation. The patient also reports radiating pain and difficulty sleeping. Satisfactory response to treatment has not been indicated by a decrease in pain level, increase in function, or improved quality of life. Therefore, ongoing use cannot be determined as medically appropriate. As such, the request is non-certified.