

<b>Case Number:</b>	CM14-0100208		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	10/22/2007
<b>Decision Date:</b>	09/23/2014	<b>UR Denial Date:</b>	06/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2014

### 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 Family Medicine and is licensed to practice in Ohio. 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 injured worker is a 47-year-old male whose date of injury is said to be 10/22/2007. Evidently he was working a call center in developed shoulder, neck and back pain. His diagnoses include myofascial pain syndrome, depression, chronic pain syndrome, cervical sprain/strain, and lumbar sprain/strain. The records reviewed span from March 2014 through May 2014. The historical information provided here prior to this is from the notes reviewed. The documentation reflects that the injured worker completed a functional restoration program in October 2013 but evidently reinjured his low back and knee while in the program. He's previously had bilateral shoulder arthroscopies and a right carpal tunnel release. He presented as a new patient to his current treating physician on March 31 of 2014. At that time he presented not taking opioids but it is unclear how long he had been off of opioids or if he had been on them at all previously. His exam revealed asymmetric shoulder girdles, limited bilateral shoulder range of motion, tenderness in the temporomandibular joints, both trapezius muscles, and the paracervical muscular group. At this initial presentation he was ordered to have physical therapy and Norco was prescribed. A follow-up notation from May 30, 2014 reflects that he Norco improved his pain by 50% and improved functionality but not specifically. The previous request to refill Norco was denied because of a lack of documentation of functional improvement and other failures to document urine drug screening, etc. The injured worker has not been employed since the date of injury.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg, BID as needed for 30 days #60, with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

**Decision rationale:** The above referenced guidelines suggest a stepwise process for opioid therapy. For a therapeutic trial of opioids there should be a treatment plan tailored to the patient. The questions to ask include: if there are reasonable alternatives to treatment, is the patient likely to improve, is their likelihood of abuse or adverse outcome, have opioids helped previously, and are there any historical inconsistencies? Before a therapeutic trial of opioids an attempt should be made to see if the pain is neuropathic or nociceptive. A therapeutic trial of opioids should not be used until the patient has failed a trial of non-opioid analgesics. Goals should be set with the continued use of opioids contingent on meeting those goals. Baseline pain and functional assessments should be made using a validated instrument or numerical rating scale. Assessment should be made of the likelihood that the patient could be weaned from opioids if there is no improvement in pain and functioning. The risks and benefits of the use of controlled substances should be discussed. Your written consent or pain agreement is suggested not required. When initiating opioids, extended-release opioids are recommended for continuous pain. For ongoing management prescription should come from a single practitioner, the lowest possible dose of medication should be used to improve pain and function. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. 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, increase level of function, or improve quality of life. The use of urine drug screening to ensure compliance should be considered. Opioid should be discontinued if there is no overall improvement function, continuing payment the evidence of intolerable adverse effects, decrease and functioning, resolution of pain, if serious nonadherence is occurring, for evidence of illegal activity, or if the patient requests it. Opioids should be continued if the patient has returned to work or has improved functioning and pain. In this instance, short-acting opioids were used for continuous pain. The documentation reflects no specificity in terms of improved functioning. There is no ongoing assessment of current pain, the least reported pain over. Since last assessment, average pain, intensity pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Therefore, Norco 10/325 mg, #60 with two refills is not medically necessary.