

<b>Case Number:</b>	CM14-0103831		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	07/18/1994
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	06/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2014

### 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 California. 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 52-year-old female who reported an injury on 07/18/1994 due to an unknown mechanism. Diagnoses were degeneration of lumbosacral intervertebral disc, degeneration of cervical intervertebral disc, chronic pain syndrome, knee pain, degeneration of lumbar intervertebral disc, and shoulder joint pain. Medications were docusate sodium, fentanyl, gabapentin, hydrocodone, Lidoderm, tizanidine, trazodone, and Wal-Zan. The physical examination dated 09/17/2014 revealed reports of depression and sleep disturbances. The injured worker also reported muscle aches and arthralgia/joint pain. The neurological examination revealed diminished sensation on the right at the C5; decreased sensation at the outer upper arm; C6 decreased sensation of the radial forearm, thumb, and index finger; decreased sensation on the lateral leg and dorsum of the foot (L5); and decreased sensation on the sole of the foot and the posterior leg (S1). The examination of the lumbar spine revealed tenderness of the paraspinal region at the L5 and tenderness sacrum. The treatment plan was for continued narcotic medication. The rationale and Request for Authorization were not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Continued narcotic medications per report dated 6/5/14: Upheld**

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

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

**Decision rationale:** The decision for continued narcotic medication per report dated 06/05/2014 is not medically necessary. The California Medical Treatment Utilization Schedule states the 4 A's for ongoing monitoring should be reported. These domains have been summarized as the 4 A's (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. It was not reported the 4 A's for ongoing management of an opioid medication. The efficacy of the medication was not reported. The name of the medication was not reported. The frequency and the quantity were not reported. The clinical information submitted for review does not provide evidence to justify continued narcotic medication per report dated 06/05/2014. Therefore, the request for Continued Narcotic Medications is not medically necessary.