

Case Number:	CM14-0136117		
Date Assigned:	08/27/2014	Date of Injury:	05/09/1996
Decision Date:	10/02/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	08/08/2014

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 & Rehabilitation, and is licensed to practice in Alabama. 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:

Progress report dated 07/22/2014 documented the patient to have complaints of ongoing back pain and muscle spasms, with burning pain in bilateral legs. She reported 50% reduction in her pain and 50% functional improvement with activities of daily living versus not taking the medication at all. She has been utilizing Lyric for her neuropathic pain. On exam, she has limited range of motion with forward flexion to 30 degrees; extension to 5 degrees; right and left straight leg raise are both 80 degrees causing right-sided back pain that radiates in the right buttock and posterior thigh. Her neck range of motion is mildly limited in all planes. Examination of bilaterally shoulders revealed limited range of motion with positive impingement signs. There is some mild crepitus on circumduction passively of both shoulder joints. She has positive Cozen's maneuvers. Impressions are cervical sprain/strain with underlying spondylosis; history of lumbar sprain/strain with lumbar degenerative disk disease, facet arthrosis, and neuropathic pain in her legs. Her Norco 10/325 is refilled. Prior utilization review dated 08/08/2014 states the request for Norco 10/325mg # 60 no refill is denied as there is no documented functional improvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg # 60 no refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioid
Page(s): 74-80.

Decision rationale: The above MTUS guidelines regarding on-going management of opioids states "Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. 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, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. 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." In this case, the patient has been on Norco since at least 3/19/14 progress note. Progress note from 7/22/14 does document "50% reduction in her pain and 50% functional improvement with activities of daily living versus not taking the medications at all. She is under a narcotic contract with our office. Urine drug screens have been appropriate." However, there is no documentation of side effects of opioids. Therefore, based on the above guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.