

Case Number:	CM14-0024826		
Date Assigned:	08/22/2014	Date of Injury:	11/14/2006
Decision Date:	12/12/2014	UR Denial Date:	02/14/2014
Priority:	Standard	Application Received:	02/26/2014

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 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:

The patient is a 54 year old female who was injured on 11/14/2006 while performing her regular job duties for the aforementioned employer, she needed to perform a mid- air catch of a copier paper box full of files that occurred while she was handing the aforementioned box: to a co-worker who failed to grab it correctly. This caused the box to fall and the patient attempted to prevent this by grabbing the box again. She experienced an immediate onset of pain in the back of her neck which was then quickly relieved. After 5 to 10 minutes, she experienced an excruciating pain in her neck, which gradually dissipated to the left shoulder, radiating down to the left arm. Prior medication history included Omeprazole 20 Mg, Ms Contin 30 mg, Naproxen 500 mg, Norco 10/325 mg, Albuterol 90 Mcg, Eflexor 75 mg, Levsin 0.125 mg and Amitiza 24 Mcg. Her surgical history included spinal fusion surgery at C5-C6 level on 5/5/2009 and left shoulder arthroscopy and decompression on 4/7/2011. Other therapies were noted to include steroid injections, chiropractic treatment, acupuncture sessions, home exercise program and activity modification. Clinical Note dated 8/8/2014 indicated the patient presented today with neck pain, her activity levels was increased. On exam, the patient appear to be in mild distress and in pain. Inspection of the cervical spine reveals surgical scar and well-healed 5cm left anterior neck horizontal 6 cm scar. Range of motion is restricted. On examination of paravertebral muscles, tenderness and tight muscle band is noted on both the sides. Tenderness is noted at the paracervical muscles, rhomboids and trapezius. Spurling's maneuver causes pain in the muscles of the neck radiating to upper extremity. Cervical facet loading is negative on both sides. Hawkins test is positive. Speeds test is negative. Yergason's test is negative. There are 3 export scars to the Left shoulder. She was diagnosed with Status Post cervical laminectomy, cervical disc disorder, shoulder pain, cervical radiculopathy and shoulder pain. The patient was recommended to continue with Norco 10/325 mg # 150. Prior UR dated 2/14/2014 modified the

request to Norco 10/325 mg #75 to allow weaning process because there is no documentation of urine drug screen performed to monitor compliance and screen for aberrant behavior and no documentation of a signed opiate agreement. Ongoing use of chronic opioids is not indicated in the current clinical setting.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #150: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75-94.

Decision rationale: The CA MTUS guidelines for 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 opi oids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) 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)." In this case, there is documentation on progress notes such as 5/2/14 stating "pain level has remained unchanged... no new problems or side effects" however there is no documentation of ongoing functional improvement or absence of aberrant drug-taking behaviors. In addition, there is no documentation of "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." Therefore, based on the above guidelines and clinical documentation provided, the request for medication as above is not deemed medically necessary.