

Case Number:	CM14-0061582		
Date Assigned:	07/09/2014	Date of Injury:	06/01/2010
Decision Date:	09/08/2014	UR Denial Date:	04/22/2014
Priority:	Standard	Application Received:	05/02/2014

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 North Carolina. 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 37-year-old with a reported date of injury listed as 4/21/2008-10/05/2012. The patient has the diagnoses of cervical spine strain/sprain, degenerative disc disease at C5/C6 and C7/T1, left shoulder sprain/strain, left elbow cubital tunnel syndrome, left elbow anterior transposition of the ulnar nerve, bilateral carpal tunnel syndrome, bilateral wrist carpal tunnel release, left median sensory neuropathy at the wrist line. Per the most recent progress notes provided by the primary treating physician, the patient had complaints of intermittent pain to the left shoulder, intermittent left elbow pain, intermittent bilateral wrist/hand/finger pain, reduced range of motion and numbness and tingling. Physical exam noted limited range of motion in the cervical spine, tenderness to palpation in the left shoulder with restricted range of motion, positive bilateral Tinel's and Phalen's sign, wrist tenderness to palpation bilaterally with restricted range of motions. Treatment plan recommendations included orthopedic consult for the increased wrist pain, internist consultation for GERD with gastritis and continuation of Norco.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5mg #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74, 78-80, 91, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids
Page(s): page(s) 76-87.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states:-Neuropathic pain: Opioids have been suggested for neuropathic pain that has not responded to first-line recommendations (antidepressants, anticonvulsants). There are no trials of long-term use. There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant neuropathy. On-Going Management. Actions Should Include:(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) 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 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). 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. (Passik, 2000)(d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management.(e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control.(f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion).(g) Continuing review of overall situation with regard to nonopioid means of pain control.(h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. Recommend that dosing not exceed 120 mg oral morphine equivalents per day, and for patients taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. Use the appropriate factor below to determine the Morphine Equivalent Dose (MED) for each opioid. In general, the total daily dose of opioids should not exceed 120 mg oral morphine equivalents. Rarely, and only after pain management consultation, should the total daily dose of opioid be increased above 120 mg oral morphine equivalents. (Washington, 2007) The long term use of opioids for the treatment of back pain is not recommended. In addition this patient, while under the care of a pain management specialist, has a MED dosage of greater than 240. There is no documentation of objective outcomes to justify this excessive dosage in the progress notes provided. For these reasons, the medication is not justified. There is no provided documentation of failure of other first line treatment options or conservative therapy. There is no documentation

of functional improvement or qualification of pain improvement on the opioids. For these reasons the medication is not certified.