

Case Number:	CM14-0034796		
Date Assigned:	12/19/2014	Date of Injury:	11/03/2013
Decision Date:	01/16/2015	UR Denial Date:	02/22/2014
Priority:	Standard	Application Received:	03/20/2014

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 38-year-old with a reported date of injury of 11/03/2013. The patient has the diagnoses of cervical, thoracic and lumbar strain, cervical radiculopathy and lumbar radiculopathy. Per the most recent progress reports provided for review from the primary treating and requesting physician dated 01/29/2014, the patient had complaints of continued pain in the neck and back. The physical exam noted tenderness in the cervical spine, pain with cervical extension and restricted range of motion. The lumbar spine exam noted tenderness to palpation, pain with flexion and extension and restricted range of motion. The thoracic spine noted tenderness with mild restriction in range of motion. There was mild decreased sensation in the C7 dermatome bilaterally. Treatment plan recommendation included chiropractic care and oral medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 2.5MG Quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids
Page(s): 76-84.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: 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, sideeffects, 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. (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 non-opioid 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. When to Continue Opioids: (a) If the patient has returned to work (b) If the patient has improved functioning and pain. The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documentation of subjective improvement in pain such as VAS scores. There is also no objective measure of improvement in function. The most recent progress notes actually indicate the patient's pain has gotten worse. For these reasons the criteria set forth above of ongoing and continued used of opioids have not been met. Therefore the request is no medically necessary.