

Case Number:	CM15-0169626		
Date Assigned:	09/10/2015	Date of Injury:	09/14/1993
Decision Date:	10/08/2015	UR Denial Date:	08/19/2015
Priority:	Standard	Application Received:	08/28/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: North Carolina

Certification(s)/Specialty: Family Practice

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 57-year-old female, who sustained an industrial injury on September 14, 1993. She reported a right arm injury. The injured worker was diagnosed as having reflex sympathetic dystrophy right arm, carpal tunnel syndrome, DeQuervain's syndrome, and status post right carpal tunnel release. Medical records (May 6, 2015 to 9/9/2015) indicate continued increased pain of the right arm and hand. Associated symptoms include frequent drops items from the hand, electrical sensations in the hand, and changes in temperature and color. She is unable to use the right arm for most home chores and requires assistance with wet laundry, vacuuming, and mopping. She reported less than 50% relief from the block in January continued. Her pain level has progressively worsened from 3 out of 10 (current good day) and 7 out of 10 (current bad day) on May 6, 2015 to 7 out of 10 (current good day) and 10 out of 10 (current bad day) on August 5, 2015. The physical exam (May 6, 2015 to August 5, 2015) reveals decreased strength of the bilateral upper extremities, decreased right wrist range of motion, hyperalgesia to pinprick, normal vibratory sensation in the upper extremities, and increased allodynia and hyperalgesia of the right forearm, hands, and fingers, which is mild to moderate most days and moderate to severe with chores. The treating physician (August 5, 2015 report) indicates that a pain management agreement is on file, Controlled Substance Utilization Review and Evaluation System (CURES) is reviewed regularly, and completed opioid risk screening questionnaires are on file. The provided medical records did not include a recent urine drug screen. Surgeries to date have included a spinal cord stimulator implantation in 2002 and right carpal tunnel release in 2008. Treatment has included postoperative hand therapy, a steroid injection, stellate ganglion blocks, heat, ice, rest, a home exercise program, postural and functional ergonomics, and medications including pain (Norco since at least May 2015).

The requested treatments included Norco 7.5-325mg. On August 19, 2015, the original utilization review non-certified a request for Norco 7.5-325mg, QTY: 90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 7.5/325mg, QTY: 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

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 4A'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 "4A'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 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(Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003)

(Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004). 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 documented significant improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function. Therefore, no criteria for the ongoing use of opioids have been met and the request is not medically necessary.