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| Case Number: | CM15-0184743 | | |
| Date Assigned: | 09/25/2015 | Date of Injury: | 09/25/2009 |
| Decision Date: | 11/03/2015 | UR Denial Date: | 09/03/2015 |
| Priority: | Standard | Application Received: | 09/21/2015 |

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 38 year old female who sustained an industrial injury on 9-25-09. A review of the medical records indicates she is undergoing treatment for left shoulder pain with a history of left shoulder surgery, cervical displacement, personal history of left-sided cervical radiculopathy, myofascial dysfunction - primarily affecting the left trapezius and left rhomboid and to a lesser extent, the left cervical paravertebral muscles with minor tone changes noted on the right-sided similar muscles, history of fibromyalgia with diagnosis dating back to 1998 or 2000, chronic opioid pain medication, depression versus reactive depression versus bipolar versus anxiety disorder - referred to psychiatry, and right-sided facial weakness "now believed to be a non-industrial cerebrovascular accident". Medical records (7-13-15) indicate complaints of neck pain with associated headaches, rating "6 out of 10" without medicine. She reports that the pain is "somewhat diminished with medicine". The report states, "the medicines are very useful", indicating "specifically Norco 10-325 that reduces her headache severity and allows her to work both at home" and at her employment. The physical exam reveals "some discomfort" with range of motion of the head, diminished range of motion of the cervical spine with "trigger points in the base of the cervical paravertebral muscles". Motor strength of the upper extremities is intact. Diagnostic studies have included an MRI of the cervical spine. Treatment has included narcotic pain medications - Norco 10-325mg every 4 hours as needed for pain. She has been taking this medication since, at least, 1-12-15. She is currently working modified duties. The utilization review (9-3-15) indicates a request for authorization of Norco 10-325mg #180, 1 tablet every 4 hours as needed for pain. This was denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10-325mg #180, one every 4 hours as needed for pain prescribed 7/13/15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Opioids dosing.

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 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. (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 or activity specifically due to the medication. Therefore not all criteria for the ongoing use of opioids have been met and the request is not medically necessary.