

Case Number:	CM15-0203672		
Date Assigned:	10/20/2015	Date of Injury:	06/01/2008
Decision Date:	12/03/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	10/16/2015

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: Montana, Oregon, Idaho
 Certification(s)/Specialty: Orthopedic Surgery

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 37 year old female who sustained an industrial injury June 1, 2008. Past history included carpal tunnel syndrome and migraines. According to a treating physician's notes dated September 18, 2015, the injured worker presented for follow-up with complaints of unchanged hand and wrist pain, rated 5 out of 10. The hand pain is bilateral, located in the thumb, index finger, middle finger, ring finger, little finger and radiates to the palm, forearm, upper arm, and shoulder. Associated symptoms included numbness, weakness, stiffness, and burning of the bilateral hands. The bilateral wrist pain is intermittent and moderate and associated with numbness, weakness, and burning, with an initial onset of (7) years ago and diagnosed as carpal tunnel syndrome. Symptoms are aggravated by movement and relieved with narcotic medication. She also reports posterior neck pain and spasm radiating to the upper back and intrascapular region, arms, and left side of neck. She developed a migraine three days ago, primarily left and right occipital radiating to the left and right temple. Current medication included ibuprofen, Norco, Zolpidem Titrated, Propranolol, and Flexeril. Objective finding included; 5'5" and 256.4 pounds; appears minimally ill in mild pain and photophobic, wearing sunglasses. No further examination documentation noted. Diagnoses are carpal tunnel syndrome; neck spas; paresthesia; migraine. Treatment plan included refilling medication. At issue, is the request for authorization for Hydroco-APAP (since at least February 5, 2015). According to utilization review dated September 22, 2015, the request for Hydroco-APAP Tab 10-325mg Day Supply: 30 Quantity: 90. Refill: (0) is non-certified and weaning is recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydroco/APAP tablets 10/325mg, #90 (30 day supply) with no refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Opioids, long-term assessment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain.

Decision rationale: According to the CA MTUS/Chronic Pain Medical Treatment Guidelines a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. 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. 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. Opioids may be continued if the patient has returned to work and the patient has improved functioning and pain. According to the ODG pain section a written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent. The lowest possible dose should be prescribed to improve pain and function. Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control is recommended. 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. The ODG-TWC pain section comments specifically on criteria for the use of drug screening for ongoing opioid treatment. The ODG (Pain / Opioids for chronic pain) states, According to a major NIH systematic review, there is insufficient evidence to support the effectiveness of long-term opioid therapy for improving chronic pain, but emerging data support a dose-dependent risk for serious harms. In this case based on the documentation there is insufficient evidence to recommend the chronic use of opioids. There is no documentation of increased level of function, percentage of pain relief, duration of pain relief, compliance with urine drug screens, a signed narcotic contract or that the injured worker has returned to work. Therefore the criteria set forth in the guidelines have not been met and the request is not medically necessary.