MAXIMUS Federal Services

Case Number:	CM15-0203778		
Date Assigned:	10/20/2015	Date of Injury:	05/08/2013
Decision Date:	12/02/2015	UR Denial Date:	09/24/2015
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 61 year old male, who sustained an industrial injury on 5-8-13. The injured worker is diagnosed with cervical spine pain, cervical spinal stenosis, myelopathy (not elsewhere classified), shoulder pain and partial left shoulder rotator cuff tear. His disability status is permanent and stationary and he is not currently working per note dated 9-18-15. Notes dated 8-21-15 and 9-18-15 reveals the injured worker presented with complaints of neck and left shoulder pain as well as poor quality of sleep. Physical examinations dated 8-12-15 and 8-21-15 revealed decreased cervical spine range of motion and pain in all arcs of movement. The right shoulder examination reveals tenderness to palpation over the right acromioclavicular joint, coracoid process and bicipital groove and decreased range of motion bilaterally. There is mild swelling noted at the left shoulder and tenderness at the left glenohumeral joint. Treatment to date has included medications; Norco (3-2015), Pennsaid cream, Celebrex (discontinued) reduce his pain from 8 out of 10 to 2-3 out of 10; functional capacity evaluation, physical therapy (40 sessions) provided mild pain relief; left shoulder steroid injection provided mild pain relief; cervical spine surgery, TENS unit reduces his pain from 5 out of 10 to 0 for 4 hours (9-18-15) and cane for stability. Diagnostic studies include urine toxicology screen is positive for Hydrocodone and Norhydrocodone per note dated 9-18-15; shoulder x-ray, cervical spine x-ray, cervical spine MRI, left shoulder MRI, cervical spine CT scan. A request for authorization dated 9-18-15 for Norco 10-325 mg #90 is denied, per Utilization Review letter dated 9-24-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, specific drug list, Weaning of Medications.

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, duration of pain relief, 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.