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| <b>Case Number:</b>   | CM14-0137414 |                              |            |
| <b>Date Assigned:</b> | 09/08/2014   | <b>Date of Injury:</b>       | 03/16/1995 |
| <b>Decision Date:</b> | 10/17/2014   | <b>UR Denial Date:</b>       | 07/30/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 08/25/2014 |

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 56-year-old female was reportedly injured on 3/16/1995. The mechanism of injury was noted as occurring during her normal work duties. The most recent progress note, dated 8/18/2014, indicated that there were ongoing complaints of neck pain that radiated in the right upper extremity, and low back pain that radiated into the bilateral lower extremities. The physical examination demonstrated lumbar spine positive spasm noted in paraspinous musculature and positive tenderness upon palpation in the spinal vertebral area of L4-S1. Upper extremity had positive tenderness at the bilateral hands. There were decreased range of motion of the right shoulder due to pain, decreased sensation to light touch in the bilateral upper extremities in both hands and decreased muscle strength in the right upper extremity. Allodynia was in the upper right extremity and hyperhidrosis in the bilateral hands. Lower extremity tenderness was noted at the right. Hypersensitivity on examination in the right lower extremity and allodynia noted in the right lower extremity. Diagnostic imaging studies included an x-ray of the lumbar spine dated 5/30/2014. No official report was available for review. Previous treatment included medications, injections, and conservative treatment. A request had been made for hydrocodone/acetaminophen 10/325 mg #150 and Nucynta 100 mg #60, and was not certified in the pre-authorization process on 7/29/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone/Acetaminophen 10/325mg #150:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91 of 127..

**Decision rationale:** Norco (hydrocodone/acetaminophen) is a short acting opiate indicated for the management in controlling moderate to severe pain. This medication is often used for intermittent or breakthrough pain. The California MTUS guidelines support short-acting opiates at the lowest possible dose that establishes improvement (decrease) in the pain complaints and increased functionality, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant has chronic pain after a work-related injury. However, there is no objective clinical documentation of improvement in the pain or function with the current regimen. As such, this request for Norco is not considered medically necessary.

**Nucynta ER 100mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines When to Continue Opioids Weaning of Medication.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG -TWC/ODG Integrated Treatment/Disability Duration Guidelines; Knee & Leg (Acute & Chronic) - Compression Garments (updated 05/14).

**Decision rationale:** MTUS/ACOEM practice guidelines do not address this request. ODG supports Nucynta as 2nd line therapy for patients with moderate to severe pain who have developed intolerable adverse effects with first-line opiates. Review of the available medical records fails to document any intolerable adverse reactions or effects to warrant the use of this medication. Given the lack of documentation, Nucynta does not meet guideline criteria and therefore is not considered medically necessary.