

Case Number:	CM15-0128822		
Date Assigned:	07/15/2015	Date of Injury:	11/19/2009
Decision Date:	08/10/2015	UR Denial Date:	06/03/2015
Priority:	Standard	Application Received:	07/02/2015

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 was a 61 year old female, who sustained an industrial injury, November 19, 2009. The injury was sustained when the injured worker got the left foot caught in metal slot of a pallet which caused the injured worker to lose her balance and falling on the left side. The injured worker previously received the following treatments cortisone injections for the left shoulder, Anaprox and Prilosec. The injured worker was diagnosed with cervical disc herniation with left upper extremity radiculopathy, lumbar myoligamentous injury with bilateral lower extremity radicular symptoms, left shoulder internal derangement with impingement syndrome, left hip internal derangement with labral tear, bilateral De Quervain's tenosynovitis and medication induced gastritis. According to progress note of April 8, 2015, the injured worker's chief complaint was cervical spine and lower back pain. The injured worker rated the pain at this visit at 7 out of 10. The pain was aggravated by bending, twisting and turning. The left shoulder pain persists which was aggravated by any overhead activity. The injured worker was experiencing pain with attempting to perform activities of daily living, such as brushing hair, brushing teeth or putting on cloths. The physical exam noted decreased range of motion in all plans of the cervical spine. There was decreased range of motion in all plans of the left shoulder and the lumbar spine. There was tenderness in the posterior cervical musculatures with bilaterally with increased muscle rigidity and muscle guarding. There was decreased sensory with Wartenberg pinprick wheel along the lateral arm and forearm bilaterally approximately in the C5-C6 distribution. There was tenderness with palpation along the left shoulder joint. There was tenderness along the right thumb extensor tendon at the base of the first dorsum

compartment. The Finkelstein's test was positive bilaterally. The examination of the posterior lumbar musculature revealed tenderness to palpation bilaterally with increased muscle rigidity. There were numerous trigger points that were palpable and tender throughout the lumbar paraspinal muscles. The treatment plan included a prescription for Norco.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 Tabs of Norco 10-325 MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-84.

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 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. (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 nonopioid 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 decrease in objective pain measures such as VAS scores for significant periods of time. There are no objective measures of improvement of function. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.