

<b>Case Number:</b>	CM15-0172627		
<b>Date Assigned:</b>	09/14/2015	<b>Date of Injury:</b>	07/26/2002
<b>Decision Date:</b>	10/14/2015	<b>UR Denial Date:</b>	07/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/01/2015

### 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 60 year old female who sustained an industrial injury on 7-26-02. A review of the medical records indicates she is undergoing treatment for lumbar radiculitis and status post fusion. Medical records (2-19-15 to 7-22-15) indicate she has had ongoing complaints of low back pain that radiates to bilateral legs and "affects activities of daily living". She has also had ongoing complaints of right neck and shoulder pain with numbness in her right arm, as well as headaches. She is status-post surgery of the left hand. Her medications include Norco 10-325 every four hours up to 6 per day, Promethazine 25mg twice daily, and Fioricet 300mg at onset of headaches. She rates her pain "4-6 out of 10". She is currently working. The physical examination indicates lumbar spine decreased range of motion; positive paravertebral tenderness; straight leg raise is positive on the left at 50 degrees and right at 60 degrees; and hyperesthesia at L5-S1. The last urinalysis in April 2014 was noted to be "consistent". The treatment plan and request for authorization included to refill Norco 10-325 every 4 hours up to 6 per day, #60, Promethazine 25mg twice daily, #60, and Fioricet 300mg at onset, #20. The utilization review (7-30-15) indicates denial of Promethazine and Norco. The rationale indicates that Promethazine is recommended as a sedative antiemetic for pre and postoperative situations and that the injured worker does not meet the criteria. The request for Norco was denied, as "there is no documentation regarding the functional benefits or any substantial functional improvement obtained with continued use of narcotic medication".

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Promethazine 25mg, #60: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Promethazine (Phenergran) for opioid nausea.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation PDR, promethazine.

**Decision rationale:** The California MTUS and the ACOEM do not specifically address the requested service. The physician desk reference states that the requested medication is indicated in the treatment of nausea. The patient has the diagnosis of nausea associated with headaches and therefore the request is medically necessary.

**Norco 10/325mg, #180: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**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 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 improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.