

Case Number:	CM15-0176064		
Date Assigned:	09/17/2015	Date of Injury:	02/18/2013
Decision Date:	10/19/2015	UR Denial Date:	09/01/2015
Priority:	Standard	Application Received:	09/08/2015

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 42 year old female injured worker suffered an industrial injury on 2-18-2013. The diagnoses included myofascitis, right bursitis and right bicipital tendinosis. On 7-15-2015, the treating provider reported right shoulder pain. There was trigger point injections in 4-2015 lasting 1 week in duration. There was moderate spasms and tenderness in the cervicobrachial junction and upper back. Trigger point injections were repeated at that visit as there was mild improvement from the prior injections. On 8-21-2015, the treating provider reported right shoulder pain rated 8 out of 10 without medications and 4 to 5 out of 10 with medications. Prior treatments included trigger point injections and medication. The documentation provided included no evidence of functional performance with the use of medication and no current aberrant drug risk assessment. The Utilization Review on 9-1-2015 determined non-certification for Colace 100mg, po BID, #60 with 4 refills and Tylenol No. 3, po, #60 with 4 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Colace 100mg, po BID, #60 with 4 refills: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 opioid therapy states: (a) Intermittent pain: Start with a short-acting opioid trying one medication at a time. (b) Continuous pain: extended-release opioids are recommended. Patients on this modality may require a dose of "rescue" opioids. The need for extra opioid can be a guide to determine the sustained release dose required. (c) Only change 1 drug at a time. (d) Prophylactic treatment of constipation should be initiated. The patient is currently on opioid therapy. The use of constipation measures is advised per the California MTUS. The requested medication is used in the treatment of constipation. Therefore, the request is medically necessary.

Tylenol No. 3, po, #60 with 4 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 non-adherent) 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 non-opioid 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 documented significant improvement in VAS scores for significant periods of time. With pain decreased from a 8/10 to a 4/10. There are no objective measurements of improvement in function or activity specifically due to the medication. Therefore, all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.