

Case Number:	CM15-0095851		
Date Assigned:	05/22/2015	Date of Injury:	01/17/2007
Decision Date:	06/24/2015	UR Denial Date:	05/02/2015
Priority:	Standard	Application Received:	05/18/2015

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 61-year-old male, with a reported date of injury of 01/17/2007. The diagnoses include neck pain, cervical discogenic disease, cervical facet syndrome, status post anterior cervical discectomy and fusion at C5-6, status post endoscopic laser decompression of C6-7, and cervical radiculitis. Treatments to date have included electrodiagnostic studies on 03/18/2013, which showed bilateral peroneal motor and posterior tibial motor neuropathy and chronic denervation of all tested muscles in both lower extremities; cervical discogram and microdecompressive cervical discectomy of C6-7 on 03/21/2013; cervical fusion on 03/21/2013; x-rays of the cervical spine; oral medications; bilateral sacroiliac joint trigger point injection; and physical therapy. The progress report dated 04/03/2015 indicates that the injured worker continued to complain of severe, constant, burning pain in her neck and shoulders and between the shoulder blades. The pain radiated to both upper extremities with the left side being worse than the right. It was noted that her symptoms remained about the same. There was intermittent numbness in both hands, spasms in both shoulders, and daily headaches that were in the back of the head. The injured worker's pain level remained a constant 10 out of 10. Any physical activity aggravated the pain. An examination of the cervical spine showed limited range of motion in both planes, painful movement, altered sensory evaluation in C5-6 and C6-7 dermatomes, decreased motor function of the upper extremities, and tenderness to palpation along the paracervical vertebral musculature. The injured worker's pain level was rated 10 out of 10 on 03/06/2015. She had severe sleep impairment and was depressed and was tearing during the visit due to ongoing, unrelenting pain. It was noted that the Norco was helpful in allowing

the injured worker to function. The treating physician requested Norco 10/325mg #150. It was noted that the injured worker's pain was relentless and constant, and her quality of life was minimal, if any and needed to be addressed. The CURES Report was reviewed and it showed compliance. The injured worker was scheduled to return in four weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, #150: Upheld

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

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 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 no documented significant improvement in VAS scores. There are also no objective

measurements of improvement in function. Therefore criteria for the ongoing use of opioids have not been met and the request is not medically necessary.