

Case Number:	CM15-0097793		
Date Assigned:	05/28/2015	Date of Injury:	07/20/2010
Decision Date:	06/29/2015	UR Denial Date:	05/01/2015
Priority:	Standard	Application Received:	05/20/2015

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 male, who sustained an industrial injury on 7/20/10. Initial complaints were not reviewed. The injured worker was diagnosed as having right shoulder high-grade partial-thickness supraspinatus tendon tear; right shoulder mild glenohumeral joint arthritis; right side long-head-of-the-biceps tenodesis; sleep disturbance due to pain; right upper extremity neuropathic pain; degenerative changes of the acromioclavicular joint with interior spurring; bursal fluid in the subacromial/subdeltoid region; left shoulder pain due to compensation; Type II acromion; aggravation right shoulder injury; right shoulder internal derangement' hypertension. Treatment to date has included status post right side long-head-of-the-biceps tenodesis (10/26/12); status post right shoulder arthroscopy revision surgery (1/24/12). Currently, the PR-2 notes dated 2/12/15 indicated the injured worker was in the office for a re-evaluation of his right shoulder pain. The provider notes exacerbating factors are heavy lifting and mitigating factors would be avoiding those maneuvers. Currently his prescribed medications are Lunesta and Norco. The injured worker is a status post Right biceps tenodesis (10/26/12) and then a status post right shoulder arthroscopy revision surgery of 1/24/12. His physical examination indicates the right shoulder range of motion was restricted by pain in all directions. His right shoulder flexion was 150 degrees with extension at 45 degrees, internal rotation 45 degrees and external rotation 70 degrees; abduction was 120 degrees. There is tenderness on palpation of the right anterior deltoid. His right shoulder impingement signs including Hawkin's and Neer's were positive. His right shoulder apprehension sign was positive as well. There is crepitus of the right shoulder and the right shoulder provocative maneuvers

were positive. Nerve root tension signs were negative bilaterally and muscle stretch reflexes were symmetric bilaterally in the upper extremities. Clonus, Babinski's and Hoffman's signs were absent bilaterally. Muscle strength in the right deltoid and 4+/5 strength in the right bicep. The provider's treatment plan includes documentation of waiting on a response for the denial of Lunesta and hydrocodone and Trazodone. He is requesting authorization of Norco 10/325mg #30 with 2 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #30 with 2 refills: Upheld

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

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 dairy 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.