

<b>Case Number:</b>	CM13-0068974		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	11/05/2002
<b>Decision Date:</b>	05/22/2014	<b>UR Denial Date:</b>	12/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2013

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 52-year-old female with date of injury 11/05/2002. Per treating physician's report on 11/27/2013, the listed assessments are: Cervical spine sprain, cervicogenic headaches, cervical facet arthropathy, reactive depression, right total knee replacement 2008 with complications, medication-induced gastritis, midback chronic pain, cervical spinal cord stimulation implant/revision 2010, revision of cervical spinal cord stimulation on 2011, and cervical occipital spinal cord stimulator placement 2013. Under treatment plan, it states, "Ongoing stretching exercise, physical therapy, NSAIDs and/or muscle relaxants have failed to control." The patient was provided with trigger point injection, referrals made to ENT, neurologist, and the medication refilled were Norco #180 among other medications including Prilosec, Fexmid, and Imitrex. The patient was to continue physical therapy. Diagnostic studies include a cervical CT scan that showed minimal disk bulges at C4-C5-C6, EMG studies from 2011 that showed bilateral C4-C5 radiculopathy, lumbar spine CT shown facet degenerative changes with bulging disks, cervical MRI from 2003 that was unremarkable. Presenting symptoms were "dystonia type symptoms," which spread to her vocal cords making very difficult for her to speak at times, difficulty swallowing both liquids and solids. Patient continues to have 6/10 pain in the neck and cervicogenic headaches with prior trigger point injections providing 50% relief lasting a couple of weeks. Medication regimen listed below allows the patient to be "as functional as possible throughout the day". The patient was completely weaned off her OxyContin which was 80 mg a day and patient's sole opiate medication continues to be Norco "which is necessary in order for the patient to have any type of activities of daily living".

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NORCO 10/325 MG #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Long Term Opioid Page(s): 78, 88-89.

**Decision rationale:** This patient presents with chronic neck strain/sprain, cervicogenic headaches, history of total knee replacement, midback chronic pain. Patient has had multiple placement revisions of the cervical spinal cord stimulation through 2010, 2011, and 2013. Current request is for Norco 10/325 #180. Review of the reports showed that the patient was weaned off of the OxyContin and is currently on Norco 10/325 six times a day. For documentation, treating physician states, "Her sole opiate medication continues to be Norco which is necessary in order for the patient to have any type of activities of daily living." For chronic opiates use, MTUS page 78 requires certain documentations including the 4As (analgesia, ADLs, adverse effects, aberrant drug-seeking behavior). Under pain assessment, it further requires documentation of least pain, average pain, reduction with pain, duration of pain relief with the use of medications. In this case, none of this information is provided. The treating physician makes a general statement that the medication is helpful with activities of daily living and function but this patient continues to have difficulties with daily function and there is no demonstration that significant improvement of activities of daily living and/or return to work has been accomplished with the use of Norco. Furthermore, this patient does not present with clear pathology of MRIs and CT scans of the cervical and lumbar spine demonstrating bulging disks, and some facet arthritic changes. In fact, cervical spine MRI from 2003 was interpreted as unremarkable. This patient does not present with clear diagnosis that would warrant chronic opiate use. For headaches, MTUS clearly states that opiates use is not recommended for example. Patient has a diagnosis of cervical spine sprain/strain syndrome for which chronic use of opiates is not recommended. Facet arthropathy does not require use of opiates. The patient may require use of some opiates for chronic knee pain but the focus of the patient's presenting symptoms are headaches and neck pain. Given the lack of adequate documentation regarding opiate use and lack of clear diagnoses that would require chronic opiate use, recommendation is for denial and slow taper of this medication. The Norco 10/325 mg #280 is not medically necessary and appropriate.