

Case Number:	CM14-0171007		
Date Assigned:	10/23/2014	Date of Injury:	03/14/2012
Decision Date:	11/21/2014	UR Denial Date:	09/15/2014
Priority:	Standard	Application Received:	10/16/2014

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 Family Practice and is licensed to practice in Ohio. 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 injured worker is a 57-year-old male with a date of injury of March 14, 2012. He had a slip and fall from the top of the truck resulting in immediate neck and low back pain. He was treated with physical therapy initially but became worse. He has been treated with opioids and muscle relaxants since the injury. He had a cervical fusion at C5-C6 on November 26, 2012 but continued to have neck and low back pain. A lumbar epidural steroid injection was not effective. He had been maintained on Nucynta 100 mg twice daily and Norco 20 mg daily for a total daily morphine equivalent dose of 100 mg. However, the treating physician was forced to reduce the dosage of Nucynta on August 4, 2014, because the perception was that the pain and functionality were not sufficiently improving. The dosage reduction was to Nucynta 50 mg every 12 hours and Norco 10/325 mg twice daily for a total morphine equivalent dose of 60 mg. On September 2, 2014, Nucynta was discontinued and a prescription for Norco 10/325 mg was provided to allow the injured worker to take up to 6 tablets daily, again for a total morphine equivalent dose of 60 milligrams a day. The plan was to reduce the total dose to 5 tablets a day in a month. The physical exam reveals tenderness to palpation and spasm in the lumbar regions, a positive straight leg raise test on the left, 5/5 right upper extremity strength, 4/5 left upper extremity strength, and diminished cervical range of motion. The diagnoses include neck pain, cervical degenerative disc disease, cervical radiculopathy, low back pain, lumbar generative disc disease, lumbar spondylolisthesis, and lumbar radiculitis. At issue is whether the initial prescription for Norco exclusively should have been 60 mg a day or 50 mg a day.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg q4-6 #180 max 6 per day times 1 month, then reduce 5 tablets per day for next month: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Drug Testing, Functional Improvement Measures Page(s): 43.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Weaning Page(s): 124.

Decision rationale: Per guidelines, opioids are recommended for a slow taper. The longer the patient has taken opioids, the more difficult they are to taper. The process is more complicated with medical comorbidity, older age, and the use of multiple agents. Gradual weaning is recommended for long-term opioid users, because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms. Patients with complex conditions with multiple comorbidities (including psych disorders) should be referred to an addiction medicine/psychiatry specialist. Opioid weaning should include the following: (a) Start with a complete evaluation of treatment, comorbidity, psychological condition; (b) Clear written instructions should be given to the patient and family; (c) If the patient cannot tolerate the taper, refer to an expert (pain specialist, substance abuse specialist); (d) Taper by 20 to 50% per week of original dose for patients who are not addicted (the patient needs 20% of the previous day's dose to prevent withdrawal); (e) A slower suggested taper is 10% every 2 to 4 weeks, slowing to a reductions of 5% once a dose of 1/3 of the initial dose is reached; (f) Greater success may occur when the patient is switched to longer-acting opioids and then tapered; (g) Office visits should occur on a weekly basis; (h) Assess for withdrawal using a scale such as the Subjective Opioid Withdrawal Scale (SOWS) and Objective Opioid Withdrawal Scale (OOWS); & (i) Recognize that this may take months. In this instance, the treating physician has converted the entire daily dose of opioids to the short acting Norco to facilitate weaning. The total daily dosage in terms of morphine equivalents was the same upon conversion. A clear plan for opioid weaning is in place. It is medically reasonable to begin with similar morphine equivalency when making the switch from long-acting to short acting opioids. Because a clear plan for opioid weaning is in place, Norco 10/325mg q4-6 #180 max 6 per day times 1 month, then reduce 5 tablets per day for next month is medically necessary per the referenced guidelines. Whether the initial daily dose in terms of morphine equivalency was 60 mg a day or 50 mg a day is medically inconsequential.