

<b>Case Number:</b>	CM14-0175648		
<b>Date Assigned:</b>	10/28/2014	<b>Date of Injury:</b>	09/26/2006
<b>Decision Date:</b>	12/05/2014	<b>UR Denial Date:</b>	09/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2014

### 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 Internal Medicine and is licensed to practice in New York. 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 54 year old male with a date of injury of 09/26/2006. He was holding a hose and it tugged and he fell on his left knee. He also has back pain. He had a medial meniscus tear on MRI. He stopped working in 2007. Subsequently he had left knee arthroscopic surgery (02/26/2007) but still has left knee pain and decreased range of motion. He also has a mood disorder and back pain. Lumbar MRI on 10/16/2014 revealed stenosis at the right L5 nerve root. In 03/2014 he was supposed to be weaned off opiates (Norco). On 04/22/2014 the left knee pain was 3-4/10. There was no deformity or effusion. He had decreased range of motion from pain. Lumbar range of motion was decreased. On 09/09/2014 he had left knee pain, poor sleep quality and decreased left knee extension. There was tenderness to palpation of the medial and lateral joint line. There was no effusion. He was taking Norco, Lidoderm patch, Gabapentin, and Baclofen. The request for Norco was modified for weaning from opiates. He takes it as needed, not daily.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78 - 79.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines were referenced for Norco. Per Chronic Pain Medical Treatment Guidelines, page 78:4) 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, sideeffects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) 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. (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 nonopioid 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. The patient documentation does not meet the above criteria for on-going opiate treatment. Therefore, this request is not medically necessary.