

<b>Case Number:</b>	CM14-0191903		
<b>Date Assigned:</b>	11/25/2014	<b>Date of Injury:</b>	01/19/2006
<b>Decision Date:</b>	01/12/2015	<b>UR Denial Date:</b>	11/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/17/2014

### 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 62 year old female with a date of injury of 01/19/2006. She had right knee pain from climbing stairs with no acute injury noted. She had right knee pain that day. X-ray that day revealed bilateral knee osteoarthritis. In 04/1996 she had right knee arthroscopic surgery (prior to the injury). She has been out of work since 01/2006. On 05/01/2009 she had a C4-C5 discectomy and fusion. On 09/01/2010 she had left shoulder rotator cuff repair with distal clavicle resection. On 11/29/2011 she had neck pain, bilateral knee pain, bilateral ankle pain, bilateral hip pain and headache. She had cervical spine paraspinal muscle tenderness. Motor strength was normal. On 04/03/2013 she had a right total knee arthroplasty. In 02/2012 she was diagnosed with lupus. On 09/13/2013 she had an office visit. She was 5 and a half month post-surgery and was P&S. She was 5'1" tall and weighed 200 pounds. The right knee had a small effusion. Quadriceps strength was 4/5. There was no patella femoral tenderness. The knee was stable. Wound was well healed. Motor and sensory exam was normal. On 01/06/2014 she was ambulating with bilateral knee braces and a walker. On average her pain was 7/10. She was taking Norco but not taking Colace. Colace was added for treatment of constipation. On 03/04/2014 she had bilateral lower extremity pain. She cannot walk without a walker. She had severe COPD. On 10/08/2014 she had an office visit with a podiatrist for ankle pain. Motor and sensory exam of both feet and ankles were normal.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #60 with 1 refill: 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 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) 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, 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. The documentation does not meet the above criteria for continued on-going opiate treatment. Therefore the request is not medically necessary.

**Colace 100mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation McKay St. Fravel M, Scanion C. Management of constipation. Iowa City: University of Iowa Gerontological nursing interventions Research center, research translation and dissemination core; 2009 Oct. P 51

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Harrison's Principles of Internal Medicine, 18th Edition. 2011.

**Decision rationale:** Opiates frequently cause constipation that is treated with over the counter stool softeners, like Colace. However, previously it was noted that the patient should be weaned from Norco and this review also notes that on-going opiate treatment is not certified. She would no longer be taking any opiates. There is no documentation that this patient requires a stool softener when not taking opiates. Colace is not medically necessary.