

Case Number:	CM14-0196862		
Date Assigned:	12/04/2014	Date of Injury:	08/27/2002
Decision Date:	01/23/2015	UR Denial Date:	10/22/2014
Priority:	Standard	Application Received:	11/24/2014

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 Occupational Medicine 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:

61 year old male injured at work on 27 Aug 2002. He was diagnosed with lumbosacral neuritis, failed low back surgery syndrome after L4-5 fusion and lumbar radiculopathy. He presently complains of ongoing low back pain with radiation into his left leg. The pain is a constant, sharp stabbing pain at 7-8/10 but improved to 5-6/10 with medications. He is able to perform activities of daily living. Exam on 14 Nov 2014 showed mildly antalgic gait, tenderness on palpation of the lumbar spine with muscle spasms noted, limited range of motion to flexion, extension and lateral flexion at the lumbar spine, decreased sensation to pinprick and light touch in the left L3, L4, L5 and S1 dermatomes and non-specific muscle weakness in the lower extremities due to pain. No imaging studies were available for review. His treatment has included surgery (lumbar L4-5 discectomy and fusion), chiropractic manipulation (not helpful), low back injections (temporary relief of symptoms) and medications (MS Contin, Norco 10/325 mg, Soma, Senna, and Flexeril). He presently is taking MS Contin 30 mg three times per day, Norco 10/325 6 tabs per day, Soma and Senna in a stable dose pattern for at least 10 months..

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 10/325mg #180: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49,Chronic Pain Treatment Guidelines CPMTG) Part 2 Page(s): 60, 74-96.

Decision rationale: Norco is a mixed medication made up of the opioid, hydrocodone, and acetaminophen, better known as Tylenol. It is recommended for moderate to moderately severe pain with usual dosing of 5-10 mg hydrocodone per 325 mg of acetaminophen taken as 1-2 tablets every 4-6 hours. Maximum dose according to the MTUS is limited to 4 gm of acetaminophen per day which is usually 60mg/day of hydrocodone (60 mg of morphine equivalent narcotic). According to the MTUS, opioid therapy for control of chronic pain, while not considered first line therapy, is considered a viable alternative when other modalities have been tried and failed. Success of this therapy is noted when there is significant improvement in pain or function. The risk with this therapy is the development of addiction. The pain guidelines in the MTUS directly address this issue and have a number of recommendations to identify when addiction develops and to prevent addiction from occurring. The present provider is appropriately monitoring this patient and notes the improvement in pain control with the use of opioid preparations. The records also document stability in dosing, in that the same dose of opioids the patient was taking 6 months ago is still in present use. This is not the pattern you will see in drug seeking addiction although in any patient on narcotics for this length of time addiction is present and if for any reason the medication is stopped then weaning must be done. Since the patient is not displaying signs of drug-seeking behavior, the medication is effective in lowering the patient's pain, the patient does not show signs of hyperalgesia and the patient is being appropriately monitored by the treating provider, chronic use of opioids in this instance is not contraindicated. However, the caveat to continue use of this medication is that the overall morphine equivalent daily opioid use in this patient must be lowered (see discussion for continued use of MS Contin) therefore the request is medically necessary.

MS Contin 30mg #90: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49,Chronic Pain Treatment Guidelines (CPMTG) Part 2 Page(s): 23, 56, 74-96.

Decision rationale: MS Contin is a controlled-release form of morphine. According to the MTUS, opioid therapy for control of chronic pain, while not considered first line therapy, is considered a viable alternative when other modalities have been tried and failed. Success of this therapy is noted when there is significant improvement in pain or function. It is important to note, however, the maximum daily dose of morphine, including morphine equivalent dosing from use of other opioid medications, is 120 mg per day. One of the major risks of opioid therapy is the development of addiction. The pain guidelines in the MTUS directly address this issue and have a number of recommendations to identify when addiction develops and to prevent addiction from occurring. Even though the present provider is following these recommendations, is appropriately monitoring this patient and notes the improvement in pain control with the use of opioid preparations, the total dose of opioids (from MS Contin and Norco

use) is 150 mg of morphine equivalents. Despite the documented stability in dosing this is significantly above the maximum dosing recommended. Because the patient is not displaying signs of drug-seeking behavior, the medication is effective in lowering the patient's pain, the patient does not show signs of hyperalgesia and the patient is being appropriately monitored by the treating provider, chronic use of opioids in this instance is not contraindicated but the dose must be lowered to a more acceptable and safe level therefore the request is medically necessary.