

Case Number:	CM14-0203018		
Date Assigned:	12/15/2014	Date of Injury:	05/19/2009
Decision Date:	02/04/2015	UR Denial Date:	11/12/2014
Priority:	Standard	Application Received:	12/04/2014

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 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:

This 43 year old male continues to complain of low back pain that radiates into the left leg, but fluctuates depending on activity and of an abnormal gait with muscle spasms, numbness and tingling, and weakness all stemming from a work related injury reported on 5/19/2009. Diagnoses include: lumbago; lumbar radiculopathy; and lumbar degenerative disc disease; neuralgia, neuritis and radiculitis; muscle, ligament and fascia disorders; sacroilitis; and low back pain. Treatments have included consultations; diagnostic MRI (9/20/13); aqua therapy (8/22/13); nerve conduction studies (12/6/13); physical therapy and home exercise program (11/5/14); orthopedic lumbar brace; TENS unit (10/23/14); lumbar transforaminal epidural steroid injections (8/5/14); and medication management. On 11/12/2014, Utilization Review non-certified, for medical necessity, a request for Norco 5/325mg, #90, citing no discussion of efforts noted to decrease or discontinue addictive fast acting opioids, or use of a non-opioid pain medication alone. Also noted was a lack of documentation to functional improvement, urine drug testing for compliance, and the lack of a signed pain contract in light of this chronic condition. The 10/28/2014, Pain management progress notes show no significant changes in subjective complaints and that the injured worker does not function as well and has decreased activities without pain medication management; which also aids him in performing his home exercise program. Examination findings note being unchanged from the previous visit and note deficits and abnormal findings, as well as atrophy and decreased sensation. These notes clearly state that an opioid agreement is located in the injured workers electronic chart. Current medications are noted to be Ibuprofen daily and Norco 5/325mg three times a day; a prescription for Valium, two pills, was noted for the IW to take prior to a scheduled procedure. Documentation noted this to be a scheduled visit, documentation of the 4 A's, recommended by guidelines, were noted, and no evidence of the violation to the opioid agreement was noted this visit. The treatment plan

noted the IW pending orthopedic follow-up with possible surgical intervention, and providing refills, without change, to the Norco because it is allowing for better pain control with increased functional improvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325mg quantity 90: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13, 78, 79, 88, 94, 95.

Decision rationale: From an AMR performed 28May14 it was reported that this consultant had evaluated the member previously on 13Sep13. The reported history was that the member was duck-walking under a building and upon getting back up experienced immediate pain in his LE and hip on or about 19May09. Initial triage was provided but eventually care was transferred to the current primary treating provider who has continued to provide supervision and care with diagnoses relevant to this injury of lumbar radiculopathy and sacroiliitis. At the end of the evaluation in 2013 the AMR consultant felt that the member had lumbar disk disease and discogenic sciatica, trochanteric bursitis and congenital hyper elasticity syndrome. He felt the member needed ongoing care by the existing PTP to include completion of aquatic therapy repeat ESI, L hip cortisone injections as well as completing an EMG. A report of an MRI 20Sep13 was compatible with a broad based disc protrusion at L5-S1 and an EMG report of 6Oct13 was compatible with a L L5-S1 radiculopathy. PT had been completed, trigger point injections had been accomplished and authorization was awaited for repeat ESI during this time frame. 31Mar14 the treating provider felt the member to have reached a point where he could be defined as permanent and stationary. The request at this time was to repeat aquatic PT. At this time the member was on Ibuprofen 600mg qam and Norco 5/325 tid. The member has not returned to work and has not recovered. He has found relief with PT, acupuncture, TENS and his current medications. Per the treating provider there is a signed Opioid Agreement in the member's electronic medical record. A review during the visit of 28Oct14 for opiate use found no evidence for any violation of that agreement (trips to the ED, lost or stolen scripts, early requests for refills etc). The member reports his pain as 8/10 without his medications and 4/10 with them. The member reports that the relief from the medication allows him to perform his home exercise program, benefits from increased tolerance for sitting and standing as well as performance of ADL's to include light household chores, cooking and personal hygiene. The member notes that his sleep and mood are better and he can function better socially with his pain under control. The member's physical examination is unchanged with limited flex and ext of the back (45 and 10 degrees), positive SLR as well as positive lumbar facet loading on the L and decreased reflexes (2/4) at the ankles and knees. The provider feels that the member is in a maintenance phase, tolerates the current medications without side effects and functions better overall. The provider continues to monitor use of medications for continued benefit using the "4 A's". The member is reported to be under assessment by an orthopedist for consideration of some

definitive surgical intervention. During the UR there were specific concerns raised re the use of fast acting narcotics and the potential for addiction. The member is reported to be in a maintenance phase which does not rule out a transition to long acting narcotics. The member has been stable with this dosage and frequency, shown sustained functional improvement on the medication and it is being used as a second line agent in conjunction with Ibuprofen, a first line agent that has been a consistent part of the member's regimen. The treating provider does indicate the existence of a signed opioid agreement and presents a detailed review of the core elements for concern which the member does not exhibit. The use of a UDS provided reasonable additional information in the face of questionable behavior but there appears to exist a long standing therapeutic relationship with no questionable behavior. Multiple modalities of care have been utilized beyond narcotic medications to include PT, home exercise, acupuncture, ESI and trigger point injections, the dose of medication shows long term efficacy with significant evidence for improvements in function to include ADL's with pain dropping from baseline off the medication at 8/10 to 4/10 with the functional improvements described previously. The provider's assessment of treatment efficacy included not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality, duration, and psychological assessment. The provider articulated following the recommended "On-going Management for Opioids" whose 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. The member did not exhibit any of the signs associated with the need to discontinue opioids such as: (a) If there is no overall improvement in function, unless there are extenuating circumstances. (b) Continuing pain with the evidence of intolerable adverse effects. (c) Decrease in functioning. (d) Resolution of pain. (e) If serious non-adherence is occurring. (f) The patient requests discontinuing. The provider is continuing to monitor using the "4 A's" and follow all the precepts laid out in the MTUS for the long term use of Opioids. On balance the provider has continued to show evidence to support the continued utility of the use of opioids in this case with clear evaluations to assess the need to modify the course of treatment or discontinue the use of opioids. He is clearly using a comprehensive approach to management and investigating interventions that even at this late date could provide a satisfactory resolution. The UR decision is not supported. The request for Norco in this case is medically necessary and I am reversing the UR decision.