MAXIMUS Federal Services

Case Number:	CM14-0209477		
Date Assigned:	12/22/2014	Date of Injury:	05/28/2010
Decision Date:	02/12/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	12/12/2014

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 Pennsylvania. 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 member has a reported DOI of 5/28/2010. No details of the injury or the preceding approach to care is available. The primary issue under review reflects ongoing issues associated with chronic low back pain. However, in the course of the review, there are references made to a separate case and a diagnosis of cervicalgia for which the same medication is apparently being utilized. There appears to have been some confusion over scripts provided to manage neck versus low back pain. The patient apparently had 1 PT session in the fall for the neck and an EMG in 2011 that reported radiculopathy involving C5, 6 and 7. At a visit 9/22/14 the patient was apparently taking Zofran, Skelaxin, Norco, Halcion, Lipitor, HCTZ and Nexium (dose and frequency unavailable). No other details are available in regard to the issues associated with the neck. An RFA for Norco and Halcion was placed with regard to the neck 9/22/14 with a UR non-certification that was later overturned after an IMR. No details are available for why the non-certification was overturned. The requested medications were released to fill 10/26/14 but another script arrived on an RFA for the same medications in regard to the members LBP 11/11/14 that could have caused an overlap in prescriptions. A script for the opioid was provided 12/11/14 and authorized 12/15/14 and another script arrived with a RFA 12/16/14 again raising an opportunity for overlap. The issue under review relates to a request for NORCO 10/325, max of 6 in any 24hrs, 180 stemming from a visit 10/28/14. The report indicated the patient suffered from a lifelong scoliosis, ongoing lumbar pain X years, with no particular incident or trauma that she can recall. The pain radiates into the buttocks bilaterally. There is no reported alteration in sensation. Pain in 7/10 made worse by prolonged sitting/standing/lifting. She gets relief with her medication and takes 3-4 of the NORCO per day. Pain is reduced to 1-2/10 with medication. Muscle spasms are relieved satisfactorily by Skelaxin but better in the past with SOMA which had been weaned and discontinued. The member had a UDS 8/28/14 compatible with her

prescriptions. Physical examination revealed a prominent R scapula consistent with the scoliosis. Lumbar ROM was normal in all directions, strength was reduced to 4/5 only in the peroneals with difficulty getting toe rise with the L foot. Sensation is reported as normal bilaterally in the LE and reflexes 2/4 throughout. The Working diagnosis was Lumbar Spondylosis. A request is made for an MRI based on worsening pain and motor deficits. The report 11/4/14 showed broad based disc bulging with associated facet hypertrophy and resultant bilateral mild to moderate inferior neural foraminal narrowing at L3-4/L4-5 and L5-S1. An RFA for NORCO 10/325 180 was also requested. The issue under review is the non-authorization of this script.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2 Page(s): 11, 13, 14, 79-81, 86, 87, 93, 95.

Decision rationale: As noted in the UR there were no objective findings to support the subjective claims of functional benefit. The patient is not on a first line agent such as an NSAID or a neuropathic first line agent such as an AED or ADD. A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Opioids, for long-term use, cannot be supported as there is a lack of evidence to allow for a treatment recommendation. A meta-analysis found that opioids were more effective than placebo for reducing pain intensity but the benefit for physical function was small and was considered questionable for clinical relevance. Opioids can be ADDED on a trial basis for short-term use after there has been evidence of failure of first-line medication options such as acetaminophen or NSAIDs when there is evidence of moderate to severe pain. If the reference to the radiation of the back pain into the buttocks bilaterally was in fact used to describe radicular/neuropathic pain then antidepressants would be considered first line agents unless found to be ineffective, poorly tolerated or otherwise contra-indicated. They represent a proven alternative and can be an option in non-neuropathic pain when associated with a diagnosis of depression as well as for chronic LBP syndromes. If chronic use of opioids is entertained, then before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. Baseline pain and functional assessments should be made. Function should include social, physical, psychological, daily and work activities. Continuation of the use of opioids would be best assessed on the basis of a return to work with evidence for improved functioning and reduced pain. The primary risk with continued use is that 36 to 56% of users have a lifetime risk for substance use disorders. Additionally there is the risk of diversion, tolerance and hyperalgesia resulting in gradual increases in medication dosing and evidence for decreasing benefits. With continuous pain extended-release opioids are recommended rather than short acting narcotic formulations. Patients on this modality may require a dose of "rescue" opioids. The need for extra opioid can be a guide to determine the sustained release dose required. In this instance use of Norco was functioning as a tid maintenance medication. Norco is considered a member of the

short-acting family of opioids and as such faces a much higher risk of rebound pain and subsequent misuse. This is not an appropriate use of short duration opioids. Weaning of opioid analgesics is recommended if there is no overall improvement in function, unless there are extenuating circumstances. This member was found to have had a stable condition with no objectively documented evidence for a sustained reduction in pain or improvement in practical function related to the use of opioids over an extended period of time. In fact there appeared to have been a decline in function according to the note which drove the request for the MRI. It is now suggested that rather than simply focus on pain severity, improvements in a wide range of outcomes should be evaluated, including measures of functioning, appropriate medication use, and side effects. Measures of pain assessment that allow for evaluation of the efficacy of opioids and whether their use should be maintained include the following: 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. An epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of these key outcome goals including pain relief, improved quality of life, and/or improved functional capacity. In the face of evidence for limited utility for improved function, recommendations for short term use of short acting opioids and the ongoing risk for rebound pain and dependence, continued use of Norco should not be supported. A decrease in dose and transition to more relevant medications for the long term management of pain with traditional first line agents as well as AED's or ADD's would be important. It was mentioned that PT had not been used in the recent past and the member had not undergone ESI or trigger point injections. Non-Certification by the UR is supported.