

Case Number:	CM14-0067467		
Date Assigned:	07/11/2014	Date of Injury:	11/10/1997
Decision Date:	12/03/2015	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	05/12/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Montana, Oregon, Idaho
 Certification(s)/Specialty: Orthopedic Surgery

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 injured worker is a 68 year old male who sustained an industrial injury on 11-10-1997. According to a progress report dated 04-16-2014, the injured worker had chronic back pain for about 17 years. He had a neurosurgical evaluation but was not considered a surgical candidate due to the diffuse nature of his spine and disk problems. He had radicular symptoms in the left leg. He reported that his back and legs felt a little bit worse over the past few weeks. He believed that the lumbar epidural steroid injection that he had in February was wearing off. His back felt worse than his leg, although he did have radicular pain, going to the left medial thigh and sometimes below the knee to the lateral foot. Straight leg raise was positive on the left for radiating pain and was negative on the right. There was increased spasm or muscle tone on both sides of the lumbar spine from L1 through L5. Reflexes remained depressed in the left leg compared to the right. Assessment included chronic back pain, lumbar disk disease, facet joint syndrome and radicular pain in the left leg. The provider noted that there had been no drug-seeking behaviors. Medications were required to enjoy a "reasonable quality of life." The provider noted that urine drug screens were performed with satisfactory results. These reports were not submitted for review. An opioid pain contract was in place, according to the provider. "The patient submitted a reassessment instrument which showed benefit from the medications and activities of daily living." The provider noted that authorization was being requested for Celebrex 200 mg #30, Flexeril 10 mg #30, OxyContin 20 mg #90, Norco 5-325 mg #60 and Neurontin 600 mg #60. Documentation shows use of Norco dating back to 2013. On 05-05-2014, Utilization Review non-certified the request for Norco 5-325 mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325 mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Opioids, long-term assessment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain.

Decision rationale: According to the CA MTUS/Chronic Pain Medical Treatment Guidelines a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. 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. 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. Opioids may be continued if the patient has returned to work and the patient has improved functioning and pain. According to the ODG pain section a written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent. The lowest possible dose should be prescribed to improve pain and function. Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control is recommended. 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 ODG-TWC pain section comments specifically on criteria for the use of drug screening for ongoing opioid treatment. The ODG (Pain / Opioids for chronic pain) states "According to a major NIH systematic review, there is insufficient evidence to support the effectiveness of long-term opioid therapy for improving chronic pain, but emerging data support a dose-dependent risk for serious harms." In this case the worker was injured in 1997. He is being treated for chronic low back pain and radicular symptoms. He has been taking Norco since at least 2013. Based on the documentation there is insufficient evidence to recommend the chronic use of opioids. Visual analog scales documenting average pain, percent reduction of pain with Norco and duration of pain relief are not included in each interval assessment, which is a requirement of the guidelines for long-term opioid use. Copies of the urine drug screen reports and opioid contract are not included in the submitted records. In addition, long-term use of opioids for the treatment of chronic pain is not supported by quality evidence. Therefore, the criteria set forth in the guidelines have not been met and the request is not medically necessary.