

Case Number:	CM15-0004480		
Date Assigned:	01/15/2015	Date of Injury:	08/18/2006
Decision Date:	03/17/2015	UR Denial Date:	01/01/2015
Priority:	Standard	Application Received:	01/08/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 51-year-old male, with a reported date of injury of 08/18/2006. The diagnoses include post-traumatic headaches, chronic lumbosacral strain, and cervical strain, lumbar radiculopathy, lumbosacral disc degeneration, neck pain, lumbar facet syndrome, and post-concussion syndrome. Treatments have included a cane, oral pain medications, electromyography/nerve conduction velocity (EMG/NCV) of the bilateral lower extremities on 02/16/2007, an MRI of the lumbar spine on 10/18/2006 and 12/23/2012, an MRI of the cervical spine on 02/19/2007, computerized tomography (CT) scan of the head on 09/15/2006, an x-ray of the lumbar spine on 09/11/2006, CT scan of the lumbar spine and thoracic spine on 08/18/2006, lumbar epidural steroid injections, lumbar transforaminal epidural steroid injections, and lumbar medial branch block. The progress report dated 12/10/2014 indicates that the injured worker complained of neck pain radiating down the right arm; back pain radiating down both legs; and low back pain. He rated his pain 3 out of 10 with medications, and 6 out of 10 without medications. The injured worker's activity level remained the same, and he is taking his medications as prescribed. The injured worker admitted that the medications were working well. The objective findings included an antalgic gait, slow gait, a wide-based gait; restricted cervical range of motion with flexion and extension, tenderness noted to the bilateral paravertebral muscles, spinous process tenderness on C5, C6, and C7, tenderness at the paracervical muscles and trapezius muscles, restricted lumbar spine range of motion, tenderness to palpation of the lumbar paravertebral muscles, spinous process tenderness on L5; positive straight leg raise test on the left side, and tenderness over the coccyx posterior iliac spine on both sides. The treating

physician indicated that the injured worker would continue his current medication regimen since it optimizes function and activities of daily living. Norco 10/325mg was requested. On 01/01/2015, Utilization Review modified the request for Norco 10/325mg #120, noting that there was no evidence of an overall improvement in function resulting from opioid use, and the guidelines recommend the discontinuation. The MTUS Chronic Pain Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-84.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: 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 nonadherent) 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 nonopioid 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. When to Continue Opioids(a) If the patient has returned to work(b) If the patient has improved functioning and pain (Washington, 2002) (Colorado, 2002)

(Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is a documented 50% reduction in pain through quantification of VAS scores. There is however no objective measure of improvement in function. For these reasons the criteria set forth above of ongoing and continued used of opioids have not been met. Therefore, the request is not certified.