

Case Number:	CM15-0167545		
Date Assigned:	09/11/2015	Date of Injury:	04/09/2013
Decision Date:	10/13/2015	UR Denial Date:	08/04/2015
Priority:	Standard	Application Received:	08/25/2015

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 48 year old male who sustained an injury on 4-9-13 resulting when he was standing on a wood beam when he slipped and fell while carrying a wood cutter that weighed approximately 10-15 pounds. He struck his right knee, right ankle and he broke a wood beam with his right leg. He felt severe pain in all affected body parts. Initially he was diagnosed with dislocated lumbar disc and torn ligaments in the right knee and right ankle. He had physical therapy 3 times a week for two months. An orthopedic evaluation on 6-19-15 indicates he continues to have cervical spine, right shoulder, lumbosacral spine, right knee and right ankle pain. The cervical spine pain is constant and he has stiffness, popping and cracking in his neck. The pain radiates to his right arm and is aggravated by movements of the head; use of the arms above the shoulder level; pushing; pulling; lifting and reaching. He rates the pain as 4 out of 10. Right shoulder pain is constant with numbness, popping and clicking and is relieved by taking a hot shower or bath, or applying heat with a heating pad. Lumbosacral pain is also constant and is described as dull and at times a sharp sensation. The pain radiates into his right leg with numbness and tingling in the right lower extremity. His pain is relieved by medication, rest, applying heat with a heating pad or taking a hot shower. He uses a lumbosacral brace support during the day. His right knee has constant pain, stiffness and swelling at times. Prolonged standing and walking aggravate his symptoms. Right ankle symptoms include pain, stiffness, numbness and tingling and are increased with prolonged standing, walking and sitting. The examination on 6-26-15 indicates a refill for Norco 1-325 mg #90 for moderate to severe pain. Notes indicated testing for medications currently in their system and the sample was sent to the

laboratory for review. Currently on 7-29-15 the examination indicates he is complaining of right ankle pain that was rated 6-7 out of 10. He states activities of daily living cause increased pain and he has complaints of pain in his right knee; cervical spine; lumbar spine and upper back regions. Diagnoses are nonunion fracture medial malleolus right ankle, status post open reduction internal fixation medial malleolus (10-5-13); lumbar spine strain, strain with spondylolisthesis at L4-L5, degenerative symptomatic, herniated lumbar disc L3-L4, L4-L5 and L5-S1 with radiculitis, radiculopathy, right greater than left; status post ACL reconstruction right knee (2-20-14); right wrist and hand strain, sprain, rule out internal derangement, TFCC tear; right hand strain, sprain, rule out tendinitis, carpal tunnel syndrome; degenerative joint disease right knee, status post Hyalgan injection x 4; status post right ankle hardware removal (12-22-14). Medications include Norco 10-325 mg. It was noted that medications were tested currently in his system to monitor compliance with the pharmacological regime. Norco 10-325 mg #90 1 every 6 hours for pain was requested. He was temporarily totally disabled.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM 2014: Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

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 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. (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 non-opioid 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 no documented significant decrease in objective pain measures such as VAS scores for significant periods of time. There are no objective measures of improvement of function. Therefore not all criteria for the ongoing use of opioids have been met and the request is not certified and therefore is not medically necessary.