

<b>Case Number:</b>	CM15-0197167		
<b>Date Assigned:</b>	10/12/2015	<b>Date of Injury:</b>	08/05/2015
<b>Decision Date:</b>	11/24/2015	<b>UR Denial Date:</b>	09/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/07/2015

### 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: Colorado

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 44 year old female who sustained an industrial injury August 5, 2015. Diagnosis is documented as lumbar strain with radiculopathy. According to a treating nurse practitioners notes dated August 12, 2015, the injured worker presented for a follow-up with constant pain to the mid back, rated 8 out of 10 with medication. The pain is aggravated by getting up, lying down, and walking. Objective findings included; midline tenderness over the lumbar spine area, tenderness on both sides of the lumbar paraspinal area, deep tendon reflexes impaired right ankle, seated and supine straight leg raise are positive on the right, Waddell's negative, Patrick's test negative bilaterally; sensation to light touch impaired in dermatomal pattern on the right side; sensations are impaired over S1 motor strength testing in the lower extremities 4 out of 5 strength; gait is antalgic, favoring the right leg. Treatment plan included return to work with modified duties, initiate physical therapy for the lumbar region, Gabapentin, and at issue, a request for authorization dated August 12, 2015, for Norco 5-325mg #60. An MRI of the lumbar spine dated September 16, 2015, (report present in the medical record) impression; at L4-L5 and L5-S1 levels there is small posterior annular tear with associated mild broad-based posterior disc bulge which is not causing any significant narrowing of the central canal, no mass effect on the spinal nerve roots. According to utilization review dated September 29, 2015, the request for Norco 5-325mg #60 is non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 5/325mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Hydrocodone/APAP, Short acting opioids, On-Going Management.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain, Opioids, differentiation: dependence & addiction, Opioids, specific drug list.

**Decision rationale:** The Guidelines establish criteria for use of opioids, including long-term use (6 months or more). When managing patients using long-term opioids, the following should be addressed: Re-assess the diagnosis and review previous treatments and whether or not they were helpful. When re-assessing, pain levels and improvement in function should be documented. Pain levels should be documented every visit. Function should be evaluated every 6 months using a validated tool. Adverse effects, including hyperalgesia, should also be addressed each visit. Patient's motivation and attitudes about pain / work / interpersonal relationships can be examined to determine if patient requires psychological evaluation as well. Aberrant / addictive behavior should be addressed if present. Do not decrease dose if effective. Medication for breakthrough pain may be helpful in limiting overall medication. Follow up evaluations are recommended every 1-6 months. To summarize the above, the 4 A's of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors) have been established. 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. Several circumstances need to be considered when determining to discontinue opioids: 1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of opioids. 2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to opioids, and aggressive or threatening behavior in clinic. Weaning from the medication over 30 day period, under direct medical supervision, is recommended unless a reason for immediate discontinuation exists. If a medication contract is in place, some physicians will allow one infraction without immediate discontinuation, but the contract and clinic policy should be reviewed with patient and consequences of further violations made clear to patient. 3) Consider discontinuation if there has been no improvement in overall function, or a decrease in function. 4) Patient has evidence of unacceptable side effects. 5) Patient's pain has resolved. 6) Patient exhibits serious non-adherence. Per the Guidelines, Chelminski defines serious substance misuse or non-adherence as meeting any of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for substances not routinely prescribed. 7) Patient requests discontinuing opioids. 8) Consider verifying that patient is in consultation with physician specializing in addiction to consider detoxification if patient continues to violate the medication contract or shows other signs of abuse / addiction. 9) Document the basis for decision to discontinue opioids. Likewise, when making the decision to

continue opioids long term, consider the following: Has patient returned to work. Has patient had improved function and decreased pain with the opioids. For the patient of concern, it is documented that patient's pain is constant. When patient came for clinic visit. August 12, 2015, pain rating was 8/10 with medications and patient had experienced no improvement over time. It appears that the Norco was initiated on August 12, 2015 to help with pain. There is no documentation of discussion of the risks of opiates and no indication patient had pain contract or urine drug screening. Per the record, patient followed up September 4, 2015 with worsening of pain, to 9/10, and Lidoderm and Ultram were added to regimen. Pain was then noted to be improved to 5/10 with medications as of September 18, 2015 office visit. Patient returned to work before Norco was initiated so opiate therapy was not relevant to work ability. No other assessment of function is documented. Patient's pain actually was worse after the addition of Norco, and there is no documented improvement in function for the patient, so the request for Norco is not medically necessary.