

<b>Case Number:</b>	CM15-0020369		
<b>Date Assigned:</b>	02/09/2015	<b>Date of Injury:</b>	05/16/2011
<b>Decision Date:</b>	03/27/2015	<b>UR Denial Date:</b>	01/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2015

### 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: Florida, New York, Pennsylvania  
 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 52-year-old male, who sustained an industrial injury on May 16, 2011. The diagnoses have included cervical spondylosis, cervical radiculitis, cervical degenerative disc disease and chronic neck pain. Treatment to date has include medication, injections, and home exercise program. Currently, the injured worker complains of neck and low back pain. He reported that he is having more pain and difficulty doing things. He is dropping more things and having daily headaches pain, weakness in his arms and more numbness. The cervical pain is described as constant, stabbing and shooting pain. He has neck tightness and muscle spasms. He reports weakness and numbness in his hands and describes the low back pain as mild diffuse aching type pain. He rates the pain a 7-8 on a 10-point scale with medications and a 4 on a 10-point scale without medications. The injured worker reports that his pain is aggravated by walking, lifting, bending and prolonged sitting and standing. His pain is relieved with lying down, injections, home exercise program and medications. On January 20, 2015 Utilization Review non-certified a request for Norco 10/325 mg #150, noting that the guidelines recommend the continuation of opioids when the patient has improved functioning and improved pain and has returned to work. The documentation submitted for review did not establish an objective assessment of the injured worker's specific response to the medication in terms of decreased pain and there was no documentation of appropriate monitoring using recent urine drug screen to ensure the compliance to the prescribed opioid regimen. The California Medical Treatment Utilization Schedule was cited. On February 3, 2015, the injured worker submitted an application for IMR for review of Norco 10/325 mg #150.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg, #150:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Part 2 Page(s): 78, 81, 82, 83.

**Decision rationale:** 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. If determined to initiate longterm opioid therapy ongoing monitoring should be initiated using the so-called 4 A's. 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. 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. It would appear to not have occurred in this case. 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. A recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of key outcome goals including pain relief, improved quality of life, and/or improved functional capacity. Based on the lack of objective measures for the response to the opioids and no apparent functional pain management the request is not medically necessary.