

<b>Case Number:</b>	CM15-0022001		
<b>Date Assigned:</b>	02/11/2015	<b>Date of Injury:</b>	10/26/2013
<b>Decision Date:</b>	04/17/2015	<b>UR Denial Date:</b>	01/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/05/2015

### 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 53 year old female, who sustained an industrial injury on 10/26/13. She has reported neck and back injury after transferring a 40 pound box into a refrigerator. The diagnoses have included strain lumbar spine and sciatica of lumbar spine. Treatment to date has included medications, Transcutaneous Electrical Nerve Stimulation (TENS), physical therapy and diagnostics. Currently, the injured worker complains of pain and discomfort in the low back rated 5/10 on pain scale. There were complaints of numbness and tingling in both legs. The pain increases with standing, sitting, walking and bending. There is also discomfort with twisting, turning, reaching, lifting and carrying. She is not wearing a back brace. She states that there is discomfort with most activities of daily living (ADL's). Physical exam revealed tenderness over the thoracic spine, decreased range of motion, pain and spasm with left rotation of the thoracic spine. The lumbar spine exam revealed she walks with antalgic gait favoring the right leg. She has difficulty with toe or heel walk bilaterally. There was tenderness to palpation and spasm over the lumbar spine. The sacroiliac joints were slightly tender on the right, range of motion was decreased, straight leg raise was positive with radiation pain into the calf bilaterally. There was hyposthesia noted over the L4, L5 and S1 dermatomes on the right. Magnetic Resonance Imaging (MRI) of the thoracic spine dated 5/1/14 revealed central disc protrusion without evidence of spinal stenosis. Magnetic Resonance Imaging (MRI) of the lumbar spine dated 10/6/14 revealed levoratory scoliosis of the lower lumbar spine and disc bulge with displacement to left exiting L4 nerve and left stenosis. Work status was permanent and stationary. On 1/20/15 Utilization Review non-certified a request for Norco 10/325mg, noting there was no documented

effort to decrease or discontinue opioids and according to the treatment guidelines medication request was not medically necessary. The (MTUS) Medical Treatment Utilization Schedule 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:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 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 improvement in VAS scores. There is no provided objective improvement in function. Therefore criteria for the ongoing use of opioids have not been met and the request is not certified.