

<b>Case Number:</b>	CM15-0022311		
<b>Date Assigned:</b>	02/11/2015	<b>Date of Injury:</b>	07/11/2003
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	01/12/2015
<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: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 70 year old female, who sustained an industrial injury on July 11, 2003. The diagnoses have included lumbar/lumbosacral disc degeneration, post laminectomy syndrome, disorder of coccyx, radiculopathy, cervical spondylosis with myelopathy, cervical disc degeneration, post cervical laminectomy syndrome, neck pain and spasm of muscle. A progress note dated December 16, 2014 provided the injured worker complains of back ache and leg pain. There is tingling in the feet and leg cramping at night. She reports the pain is rated 6/10 with medication and poor sleep quality. Her activity level is decreased since last visit. She is finished with physical therapy and uses a cane for ambulation. She reports the Transcutaneous Electrical Nerve Stimulation (TENS) unit is very helpful for pain control. On January 12, 2015 utilization review non-certified a request for Norco 10-325mg #60,1 refill and outpatient services for low back pain. Application for independent medical review (IMR) is dated February 5, 2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10-325MG #60, 1 Refill:** Overturned

**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 section Page(s): 74-95.

**Decision rationale:** The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. The medical documentation reports that the injured worker is on chronic pain medications and she needs these medications to remain functional. The requesting physician has established an opioid agreement with the injured worker. The injured worker's opioid medication dosing has remained stable and, and she appears to be in a maintenance stage of his pain management. Utilization review opinions that the functional improvement is not significant with the use of opioid pain medications. The injured worker reports significant pain reduction with her medications and her functional limitations are actually improved over twice that of when she is not taking medications. She is not working, but her limitations remain rather significant and she is of retirement age. The request for Norco 10-325MG #60, 1 Refill is determined to be medically necessary.

**Outpatient Services for Low Back Pain:** Overturned

**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 Criteria for Use of Opioids section, Opioids Dosing section Page(s): 78, 86.

**Decision rationale:** The MTUS Guidelines recommend consultation with pain management if opioid are required for extended periods (beyond what is usually required for the condition) or if pain does not improve on opioids in three months. Pain management consultation is also recommended for the rare case when total daily opioid therapy exceeds 120 mg oral morphine equivalents. The injured worker is being treated chronically with opioid pain medications. She is being treated by a pain specialist, and should continue to have outpatient services routinely to ensure proper evaluation and management. The request for Outpatient Services for Low Back Pain is determined to be medically necessary.