

Case Number:	CM15-0224707		
Date Assigned:	11/23/2015	Date of Injury:	01/08/1999
Decision Date:	12/31/2015	UR Denial Date:	10/20/2015
Priority:	Standard	Application Received:	11/16/2015

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: Montana, Oregon, Idaho
 Certification(s)/Specialty: Orthopedic Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 52 year old female who sustained a work-related injury on 1-8-99. Medical record documentation on 10-15-15 revealed the injured worker was being treated for complex regional pain syndrome of the right upper limb, lateral epicondylitis of the right elbow, neuropathic pain and cervical paraspinous muscle spasm. She reported low back pain. Objective findings included cervical spine pain with anterior flexion of the neck and extension of the neck. The injured worker had a normal gait and was able to heel walk and toe walk. Her medication regimen included Colace 100 mg, Norco 10-325 mg (since at least 6-14-15), Trazodone 100 ng, Robaxin 750 mg and Miralax 17 gm. She reported that her pain level without use of Norco was a 10+ on a 10-point scale and with Norco the pain rating was 2 on a 10-point scale. Previous therapy included spinal cord stimulator implantation and OxyContin. The evaluating physician noted that her previous urine drug screen was consistent for hydrocodone and that there was no evidence of abuse, diversion, hoarding or impairment. A urine drug screen performed on 5-20-15 revealed results inconsistent with the injured worker's medication regimen. A request for Norco 10-325 mg #210 was received on 10-19-15. On 10-20-15, the Utilization Review physician modified Norco 10-325 mg #210 to Norco 10-325 mg #165.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 #210: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Opioids, long-term assessment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain.

Decision rationale: According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. 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. 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. Opioids may be continued if the patient has returned to work and the patient has improved functioning and pain. According to the ODG pain section 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. The lowest possible dose should be prescribed to improve pain and function. Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control is recommended. 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. The ODG-TWC pain section comments specifically on criteria for the use of drug screening for ongoing opioid treatment. The ODG (Pain / Opioids for chronic pain) states: According to a major NIH systematic review, there is insufficient evidence to support the effectiveness of long-term opioid therapy for improving chronic pain, but emerging data support a dose-dependent risk for serious harms. In this case, the injured worker is 52 years old and was injured in 1999. She is being treated for complex regional pain syndrome, cervicgia and low back pain. She has been prescribed Norco since at least 6/14/15. Based on the documentation there is insufficient evidence to recommend the chronic use of opioids. There is no documentation of increased level of function, duration of pain relief, a signed narcotic contract or that the injured worker has returned to work. The current guidelines provide very limited support to recommend treatment of non-malignant pain beyond 16 weeks. Therefore, the criteria set forth in the guidelines have not been met and the request is not medically necessary.