

Case Number:	CM15-0041387		
Date Assigned:	03/11/2015	Date of Injury:	08/08/2013
Decision Date:	04/15/2015	UR Denial Date:	02/09/2015
Priority:	Standard	Application Received:	03/04/2015

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 47-year-old male, who sustained an industrial injury on 8/8/13. He has reported twisting and falling off water truck on his right knee. The diagnoses have included knee/leg pain, lumbar radiculopathy, head injury and depression with anxiety. Treatment to date has included medications, diagnostics, surgery, injections, and cane. Surgery included right knee surgery on 4/18/14. Currently, as per the physician progress note dated 1/9/15, the injured worker complains of low back pain with depression. He states that Morphine Sulfate did help but made him too sleepy and he is also complaining of incontinence issues. He is also still having difficulty with knee pain and difficulty ambulating. He has finished a course of orthovisc injections on 8/13/14 and states that it did not help very much. Because of the right knee pain and putting all the weight on the left knee, the left knee has been popping and there is pain. He recently fell because the right knee gave out. He also states that because he must use a cane to ambulate and support himself with the right hand the right wrist is bothering him. Physical exam of the lumbar spine revealed muscle spasm, tightness, tenderness and decreased range of motion. The right knee exam revealed decreased range of motion. The left knee exam revealed tenderness to touch. The right wrist exam revealed tenderness with decreased range of motion. The requested treatments included home health evaluation, orthopedic consult, Magnetic Resonance Imaging (MRI) and x-ray of the left knee, pain management consult, urology consult, psychological consult, bilateral crutches, wheeled walker, shower chair, adult male incontinence pads, Norco, Morphine Sulfate, Flexeril, and Naproxen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg, sixty count: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chapter 12 Low Back Complaints Page(s): 303 - 305 and 341 - 343, respectively, Chronic Pain Treatment Guidelines Opioids - Criteria for Use Section. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), page 132.

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 documentation of significant subjective improvement in pain such as VAS scores. There is also no objective measure of improvement in function. For these reasons the criteria set forth above of ongoing and continued used of opioids have not been met. Therefore the request is not certified.