MAXIMUS Federal Services

Case Number:	CM15-0063282		
Date Assigned:	04/09/2015	Date of Injury:	05/01/2012
Decision Date:	07/17/2015	UR Denial Date:	03/12/2015
Priority:	Standard	Application Received:	04/02/2015

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
Certification(s)/Specialty: Neurology, Pain Management

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 42 year old male, who sustained an industrial injury on 5/01/2012. Diagnoses include left knee internal derangement status post surgery x2 and right knee pain compensatory in nature. Treatment to date has included surgical intervention left knee arthroscopy, partial meniscectomy and chondroplasty (12/13/2013), diagnostics and medications including anti-inflammatories and Norco and physical therapy. Per the Comprehensive Pain Management Consultation, Review of Medical Records and Request for Authorization dated 2/25/2015, the injured worker reported Physical examination of the left knee revealed bilateral joint line tenderness with range of motion 0-100 with cracking and crepitation. There as mild swelling noted. Examination of the right knee revealed bilateral joint line tenderness with range of motion 0-110 degrees. The plan of care included, and authorization was requested on 3/06/2015, for Norco 10/325mg, a urine drug screen 4 times a year and reevaluation with [redacted]

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80-82. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Opioids, criteria for use.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation official disability guidelines -pain, opioids.

Decision rationale: ODG guidelines support opioids with: 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. The medical records report chronic pain but does not document ongoing opioid risk mitigation tool use in support of chronic therapy congruent with ODG guidelines. As such, chronic opioids are not supported. Therefore, the request is not medically necessary.

Urine drug screening 4 times a year (randomly): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Drug Testing; Urine Drug Testing (UDT).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation official disability guidelines - pain, opioids.

Decision rationale: ODG guidelines note -At the onset of treatment: (1) UDT is recommended at the onset of treatment of a new patient who is already receiving a controlled substance or when chronic opioid management is considered. Urine drug testing is not generally recommended in acute treatment settings (i.e. when opioids are required for nociceptive pain). (2) In cases in which the patient asks for a specific drug. This is particularly the case if this drug has high abuse potential, the patient refuses other drug treatment and/or changes in scheduled drugs, or refuses generic drug substitution. (3) If the patient has a positive or "at risk" addiction screen on evaluation. This may also include evidence of a history of comorbid psychiatric disorder such as depression, anxiety, bipolar disorder, and/or personality disorder. See Opioids, screening tests for risk of addiction & misuse. (4) If aberrant behavior or misuse is suspected and/or detected. See Opioids, indicators for addiction & misuse. Ongoing monitoring: (1) If a patient has evidence of a "high risk" of addiction (including evidence of a comorbid psychiatric disorder (such as depression, anxiety, attention-deficit disorder, obsessive-compulsive disorder, bipolar disorder, and/or schizophrenia), has a history of aberrant behavior, personal or family history of substance dependence (addiction), or a personal history of sexual or physical trauma, ongoing urine drug testing is indicated as an adjunct to monitoring along with clinical exams and pill counts. See Opioids, tools for risk stratification & monitoring. (2) If dose increases are not decreasing pain and increasing function, consideration of UDT should be made to aid in evaluating medication compliance

and adherence. The medical records provided for review do not document a formal assessment of addiction risk. As the medical records do not support these assessments, UDS is not supported for current care. Therefore, the request is not medically necessary.