

Case Number:	CM14-0213928		
Date Assigned:	12/31/2014	Date of Injury:	03/23/2009
Decision Date:	03/20/2015	UR Denial Date:	12/15/2014
Priority:	Standard	Application Received:	12/22/2014

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: 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 following clinical case summary was developed based on a review of the case file, including all medical records: This 26-year-old customer service representative reported injuries to her left ankle and low back after a fall from on 11/1/08, with a second left ankle injury which occurred while stepping out an airplane on March 23, 2009. Her past medical history is notable for extreme obesity (BMI 48.4). Her diagnoses include lumbar disc displacement without myelopathy, lumbar radiculopathy, lumbar degenerative disc disease, and lumbosacral sprain/strain, and status post left foot and ankle surgery for tendonitis and sinus tarsi syndrome. Her original ankle surgery was on 9/3/10. On 8/27/1414, a second ankle surgery with synovectomy of the left subtalar joint and debridement of the left sinus tarsi, synovectomy, and release of peroneal tendon sheaths. She had been treated pre-operatively with orthotic devices, ankle support, injection therapy, physical therapy, pain medication, home exercise program, moist heat, and stretches. Post-operatively, she has been treated with a boot, crutches, activity modifications, physical therapy, and pain medication. On October 22, 2014, her treating orthopedist reports the injured worker walks with a boot and crutches. The injured worker complains of left leg pain since falling one week after surgery, lower back pain with right thigh numbness, left foot sensitive to touch, and stomach pain. The physical exam revealed a well healed wound, no swelling, sensitivity to touch in the dorsum of the foot, sensitivity of the anterior distal thigh on the right side, and lumbar spine motion tenderness without motor or sensory deficit in neuro exam. The treatment plan includes pain and proton pump inhibitor medications, use boot for walking - partial weight bearing and start putting away the crutches,

and continue physical therapy. The patient is also followed by pain specialists, who have been prescribing Norco to this patient since at least 3/13/12 (the earliest clinical note in the available records). Apparently the Norco was being gradually decreased until the patient's 8/27/14 surgery, at which point it was increased and has remained at a level of one Norco 5/325 3 times per day. A 12/15/14 UR note makes reference to an 11/19/14 progress note from one of the pain specialists which is not contained in the records available to me. The note is cited as stating that the patient has ongoing ankle and back pain, that she continues to use an ankle brace, and that her heel and toe walk are unsteady. Norco 5/325 #150 was prescribed, with the stated hope that the patient will be able to decrease the Norco to pre-surgery levels. My review of the available notes from the pain specialists reveals that no functional goals are ever mentioned for Norco use, and that the patient's level of function, while not explicitly described, does not appear to have changed since her surgery except that she has graduated from a boot and crutches to an ankle brace, possibly with a cane. All of the notes document the patient as working at modified duty, though it is not entirely clear whether or not this statement is a template carryover. If it is, the patient may not actually be working. The records contain copies of five previous instances in which Norco was reviewed in UR and modified to a smaller number for weaning purposes, or non-certified altogether. The most recent of these is an 11/12/14 UR which non-certified Norco 5/325 #150. It appears that the treating pain specialists largely have ignored these UR decisions. On December 15, 2014 Utilization Review non-certified a prescription for Norco 5/325mg #150, noting the guidelines recommendation of a one month time limit on opioid prescriptions for chronic pain, and it is not reasonable for the injured worker to rely on an opioid analgesic at this point post-operatively. The California Medical Treatment Utilization Schedule (MTUS), Chronic Pain Medical Treatment Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5-325mg #150.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, page 60, Criteria for Use of Opioids, Steps to Take Before a Thera.

Decision rationale: Norco 5/325 is brand-name hydrocodone 5 mg with acetaminophen 325 mg. Hydrocodone is an opioid analgesic. Per the MTUS recommendations cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. Opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine if the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Opioids should be discontinued if there is no improvement in function. There is no good evidence that opioids are effective for radicular pain.

If long-term use of opioids occurs, there is a need for ongoing pain and function assessments, as well as assessments for side effects, of concurrent other treatments, and of concurrent psychological issues. The clinical findings in this case do not demonstrate that any of the above guidelines have been followed. This patient has been taking Norco for at least 2 years and 8 months. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. Given this patient's diagnosis of radiculopathy, and her treating physicians' concerns about, and testing for complex regional pain syndrom, it appears quite likely that her pain includes a significant neuropathic component, which is not necessarily likely to respond to an opioid. No assessment is documented of whether or not opioid use was likely to be helpful to this patient, or of her potential for abuse. Given her extreme obesity, she probably has some potential for abuse and addiction, and that possibility is supported by her physicians' inability to wean her off Norco months after her last surgery. No specific functional goals were set or followed. Most importantly, Norco was not discontinued when it became clear that it has not produced any functional improvement. Although it is not entirely clear what this patient's work status is, it is clear that it has not changed. Based on the evidence-based guidelines cited above, and the clinical documentation provided for my review, Norco 5/325 #150 is not medically necessary. It is not medically necessary because of the lack of appropriate documentation of the patient's status prior to beginning it, because of the failure to set and monitor functional goals, and because of the failure to discontinue it when it became clear that it has not produced any functional recovery.