

Case Number:	CM15-0173172		
Date Assigned:	09/15/2015	Date of Injury:	09/05/1995
Decision Date:	10/14/2015	UR Denial Date:	08/19/2015
Priority:	Standard	Application Received:	09/02/2015

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: 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 63 year old male, who sustained an industrial injury on September 5, 1995. The injured worker was diagnosed as having lumbar spondylosis without myelopathy, lumbar spine degenerative disc disease, lumbar spinal stenosis, lumbago, cervical spondylosis without myelopathy, cervical herniated disc, cervical spinal stenosis, cervical degenerative disc disease, and cervicalgia. Medical records (April 15, 2015 to July 10, 2015) indicate worsening of the injured worker's chronic neck pain that radiates to the right shoulder and constant midline low back pain with constant pins and needles pain in the bilateral lower extremities. The injured worker's pain was rated: neck equals 8 out of 10 and back equals 9-10 out of 10. The injured worker reports flare-ups of low back pain. He reports using an electric wheel and ropes to get around his house. Per the treating physician (April 15, 2015 report), the injured worker has not worked since 2009. The physical exam (July 10, 2015) reveals active cervical range of motion of 20 degrees and negative Spurling's test bilaterally. There is a well-healed midline lumbar surgical incision, tenderness to palpation along the bilateral lower lumbar paraspinal muscles, and full active lumbar range of motion. There is 5 out of 5 muscle strength of all extremities, except for 4- out of 5 strength of the right elbow extension. There is decreased sensation to pinprick in all extremities. Surgeries to date have included fusion at L4-5 (lumbar 4-5) in 1999 and fusion at L5-S1 (lumbar 5-sacral 1) in 1996. Treatment has included 12 sessions of physical therapy with moderate relief, 24 sessions of physical therapy with minimal relief, 8 sessions of chiropractic with minimal relief, 25 sessions of acupuncture, lumbar transforaminal epidural steroid injection with 30% relief for 9 days, a heating pad, and medications including pain

(Norco 10-325mg since at least February 2015), sleep, antidepressant, and muscle relaxant. On July 10, 2015, the requested treatments included Norco 10-325mg. On August 19, 2015, the original utilization review partially approved a request for Norco 10/325 #150 to allow for weaning.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10-325mg #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter: Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

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 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 documented significant decrease in objective pain measures such as VAS scores for significant periods of time. There are no objective measures of improvement of function or how Norco improves activities. The work status is not mentioned. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.