

Case Number:	CM15-0179148		
Date Assigned:	09/21/2015	Date of Injury:	08/02/2005
Decision Date:	10/23/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application	09/11/2015

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 43 year old female who sustained an industrial injury on 08-02-20-05. Diagnoses include low back pain, myofascial pain, chronic pain syndrome, lumbar degenerative disc disease, lumbar discogenic pain, and possible lumbar radiculitis. She has comorbid diagnoses of intrinsic asthma and rheumatoid arthritis. A physician progress note dated 08-14-2015 documents the injured worker has complaints of continued low back pain as well as pain in the mid-low back and into the left hips and posteriorly down the right leg with prolonged walking. She has a pins and needles sensation in her feet. On examination, there is tenderness to her paraspinal and she has decreased range of motion with increased pain. There is positive straight leg raise bilaterally. She ambulates with an antalgic gait. She takes Norco for moderate to severe pain, Naproxen for inflammation and Omeprazole for gastrointestinal upset from medications. She can take care of her son with the help of her medications, and is able to be more social and active. She states without the Norco she cannot function. Her pain is 7 out of 10 without medications and 1 out of 10 with medications. She complains of depression and anxiety. A progress note dated 07-16-2015 documents she presents for a medication refill. Her pain without medications is rated 6 out of 10 and with medications her pain is 2-3 out of 10. This is unchanged since her last visit one 06-18-2015. She has been on Norco since at least December of 2014. Treatment to date has included diagnostic studies, medications, injections, use of Transcutaneous Electrical Nerve Stimulation unit, and lumbar epidural steroid injections which in the past provided 50% pain relief for over 2 months. A Magnetic Resonance Imaging of the lumbar spine done on 07-25-2015 revealed relatively mild degenerative changes within the lumbar spine with no evidence of significant spinal canal or neural foraminal stenosis. Request for Authorization dated 08-19-2015 is for Anaprox 550mg #60 x 4, Norco 5-325mg #60 and Prilosec 20mg #60. On 08-27-2015 the Utilization Review

non-certified the request for retrospective request for Norco 5/325mg #60, date of service 08/14/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Norco 5/325mg #60, date of service 08/14/2015: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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 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 documented significant improvement in VAS scores for significant periods of time with pain decreasing from a 7/10 to a 1/10. There are objective measurements of improvement in function or activity specifically due to the medication. Therefore, all criteria for the ongoing use of opioids have been met and the request is medically necessary.