

<b>Case Number:</b>	CM15-0069742		
<b>Date Assigned:</b>	05/18/2015	<b>Date of Injury:</b>	06/28/2007
<b>Decision Date:</b>	06/17/2015	<b>UR Denial Date:</b>	03/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/13/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 53 year old male, who sustained an industrial injury on June 28, 2007. The injured worker was diagnosed as having lumbar intervertebral disc displacement, thoracic/lumbosacral neuritis/radiculitis, leg and knee sprain and sciatica. Comorbid conditions include obesity (BMI 31). Treatment and diagnostic studies to date have included medication, physical therapy, home exercise program and epidural steroid injections. A progress note dated January 19, 2015 provided the injured worker complained of back and bilateral leg pain. He rated the pain 6/10. At its best the pain is 3/10 and at the worst 9/10. He reported numbness and tingling in both legs. The pain has resulted in notable stress and anxiety. Physical exam noted tenderness with decreased lumbar range of motion (ROM). The plan included Norco, omeprazole, urine drug test and home healthcare.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NORCO 5/325MG #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-9, Chronic Pain Treatment Guidelines Medications for chronic pain; Opioids Page(s): 60-1, 74-96.

**Decision rationale:** Hydrocodone-Acetaminophen (Norco) is a mixed medication made up of the short acting, opioid, hydrocodone, and acetaminophen, better known as Tylenol. It is recommended for moderate to moderately severe pain with usual dosing of 5-10 mg hydrocodone per 325 mg of acetaminophen taken as 1-2 tablets every 4-6 hours. Maximum dose according to the MTUS is limited to 4 gm of acetaminophen per day, which is usually 60-120 mg/day of hydrocodone. According to the MTUS opioid therapy for control of chronic pain, while not considered first line therapy, is considered a viable alternative when other modalities have been tried and failed. Success of this therapy is noted when there is significant improvement in pain or function. The risk with this therapy is the development of addiction, overdose and death. The pain guidelines in the MTUS directly address this issue and have outlined criteria for monitoring patients to allow for safe use of chronic opioid therapy. There is no documentation in the records available for review that the present provider used first-line medications before starting opioid therapy or that the patient has signed a pain medication contract to ensure the safe use of chronic opioids. Medical necessity for continued use of this medication has not been established.

**1 URINE DRUG SCREEN:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48, Chronic Pain Treatment Guidelines Chronic pain programs, opioids; Medications for chronic pain; Opioids Page(s): 34, 60, 74-96. Decision based on Non-MTUS Citation 1) American Society of Interventional Pain Physicians (ASIPP) Guidelines for Responsible Opioid Prescribing in Chronic Non-Cancer Pain: Part I ? Evidence Assessment, Pain Physician 2012; 15:S1-S662) Keary CJ, Wang Y, Moran JR, Zayas LV, Stern TA. Toxicologic Testing for Opiates: Understanding False-Positive and False-Negative Test Results. The Primary Care Companion for CNS Disorders. 2012;14(4):PCC.12f01371. doi: 10.4088/PCC.12f01371 available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3505132/>.

**Decision rationale:** A drug test is a technical analysis of a biological specimen, for example urine, hair, blood, breath air, sweat, or oral fluid / saliva, to determine the presence or absence of specified parent drugs or their metabolites. Drug testing a blood sample is considered the most accurate test for drugs or their metabolites but is more time consuming and expensive than urine testing. In fact, Keary, et al, notes that most providers use urine toxicology screens for its ease of collection and fast analysis times. According to the MTUS, urine drug testing is recommended as an option for screening for the use of or the presence of opioid and/or illegal medications. It recommends regular drug screening as part of on-going management of patients on chronic opioid therapy 2-4 times per year. The American Society of Interventional Pain Physicians guidelines specifically notes use of urine toxicology screens to help assess for patient abuse of medications and comments that this method of screening has become the standard of care for

patients on controlled substances. Review of the available medical records for this patient reveals that the patient had a urine drug screen one month prior to this request (Dec 2014). In addition, there is no documentation suggesting aberrant drug seeking behavior by the patient. There are no indications of a need for a repeat urine drug screen this soon after the last test. Medical necessity for this procedure has not been established.