

<b>Case Number:</b>	CM15-0094134		
<b>Date Assigned:</b>	05/20/2015	<b>Date of Injury:</b>	12/03/2013
<b>Decision Date:</b>	06/24/2015	<b>UR Denial Date:</b>	05/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/15/2015

### 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 52 year old male, who sustained an industrial injury on 12/03/2013. He has reported injury to the neck, right shoulder, and low back. The diagnoses have included lumbar myoligamentous injury with left lower extremity radiculopathy in the L5-S1 distribution; cervical myoligamentous injury; and right shoulder impingement syndrome. Treatment to date has included medications, diagnostics, lumbar epidural steroid injections, physical therapy, and home exercise program. Medications have included Norco, Ultracet, Prilosec, Neurontin, and Anaprox. A progress note from the treating physician, dated 04/21/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of increased pain in his lower back which radiates down to both lower extremities; pain is rated as an 8, on a scale from 0-10; has been unable to sit and stand for no longer than 10 to 15 minutes due to pain which limits both his mobility and activity tolerance; sleeping poorly at night due to his ongoing low back pain; has had notable improvement with prior lumbar epidural steroid injections; good pain relief, by 40-50%, with Norco; and with his medications, he is able to function on a daily basis, actively participate in a home exercise program with less pain, and perform simple chores around the house with less discomfort. Objective findings included tenderness to palpation in the posterior cervical spine musculature, trapezius, medial scapular, and sub-occipital region; there are multiple trigger points and taut bands palpated throughout the cervical region; tenderness to palpation in the lateral and subacromial bursa region of the right shoulder; tenderness to palpation about the lumbar paravertebral musculature and sciatic notch region; there are trigger

points and taut bands with tenderness to palpation of lumbar spine. The treatment plan has included the request for Norco 10/325mg #60.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Norco 10/325 mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-84.

**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 nonopioid 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 improvement in VAS scores. There are also no objective measurements of improvement in function. Therefore criteria for the ongoing use of opioids have not been met and the request is not medically necessary.