

<b>Case Number:</b>	CM15-0098728		
<b>Date Assigned:</b>	06/01/2015	<b>Date of Injury:</b>	08/25/2009
<b>Decision Date:</b>	06/30/2015	<b>UR Denial Date:</b>	04/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/21/2015

### 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 54-year-old male, with a reported date of injury of 08/25/2009. The diagnoses include lumbosacral sprain; internal derangement of the right knee; status post right knee replacement; right fifth digit phalanx fracture; carpal tunnel syndrome; status post carpal tunnel release; right trochanteric bursitis; lumbar spinal stenosis; right sacroiliac sprain; and anomalies of the foot, status post surgery. Treatments to date have included oral medications; topical pain medication; x-rays of the right ankle on 01/25/2010; an MRI of the right knee; an MRI of the lumbar spine on 03/29/2013; and x-rays of the left ankle on 03/11/2014. The progress report dated 04/15/2015 indicates that the injured worker noted increased pain since he ran out of Norco. The chief complaint was noted as low back, bilateral wrists, right foot, ankle, and knee pain. It was reported that the injured worker felt anxious and somewhat nauseated. The pain was rated 6-7 out of 10. The current medications provided about 50% decrease in his symptoms, but only temporarily. The physical examination showed atrophy of the distal muscle of the lower extremities; limited range of motion of the bilateral ankles, right more than left; tenderness of the right fifth toe and metatarsal; tenderness of the right medial knee joint; moderate tenderness of the greater trochanter; tenderness of the right gluteus medius and TFL (tensor fasciae latae) muscle; mild decreased range of motion in the lumbar spine due to pain; mild to moderate tenderness of the lumbar spine and paraspinals with tightness on the left; moderate to severe point tenderness of the right sacroiliac joint; mild decreased light touch and pinprick sensation in the right distal foot; diminished reflexes in the ankles and right knee; and negative straight leg raise test. It was noted that the injured worker was having withdrawal

symptoms since he was not provided with Norco. The progress report dated 03/24/2015 indicates that the injured worker continued to have low back pain, and the pain was rated 5 out of 10. The treating physician requested Norco 10/325mg #90 with three refills.

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

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

**Norco 10/325 MG #90 with 3 Months of Refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids  
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**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 no documented significant improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.