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| Case Number: | CM13-0051019 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 04/06/1999 |
| Decision Date: | 02/15/2014 | UR Denial Date: | 10/16/2013 |
| Priority: | Standard | Application Received: | 10/30/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Medicine, has a subspecialty in Preventive Medicine, and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 41 yr. old male claimant sustained an injury on 4/6/99 while working as a machine operator that resulted in chronic back pain. He had filed therapy and epidural injections for discogenic disease. He had a lumbar fusion performed and continued to have radicular symptoms with myofascial pain. A progress note by neurosurgery 11/20/12 noted he had been on Cymbalta, Methadone, Nortryptiline, Oxycodone, Diazepam, Skelaxin, and Soma. He was noted have "Opioid Dependency." A progress note on 6/21/13 indicated evaluation for chronic regional pain and continued to be on the same muscle relaxants and opioids including Oxycodone 30mg-6 times a day. He was encourages to exercise, use a back brace and the medications were continued. A progress note on 9/9/13 notes that the patient was requesting he go to the Emergency Department (ED) when he has pain and was permission to go as needed. He was continues on Norco 10mg/325 3 times a day along with Methadone and Oxycodone.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg tab, #240 for the lumbar spine pain, as an outpatient: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Goodman and Gillman's The Pharmacological basis of therapeutics, Physician's Desk reference, and Epocrates online.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77-92.

Decision rationale: In the case misuse, these concerns should be addressed immediately with the patient. The MTUS guidelines indicate that if there are active signs of relapse to addiction, or new-onset addiction, these patients should be referred to an addictionologist immediately. It has been suggested that most chronic pain problems will not resolve while there is active and ongoing alcohol, illicit drug, or prescription drug abuse. (Weaver, 2002) Many physicians will allow one "slip" from a medication contract without immediate termination of opioids/controlled substances, with the consequences being a re-discussion of the clinic policy on controlled substances, including the consequences of repeat violations. If there are repeated violations from the medication contract or any other evidence of abuse, addiction, or possible diversion, it has been suggested that a patient show evidence of consultation with a physician trained in addiction treatment for assessment of the situation and possible detoxification. The guidelines also suggested that a patient be given a 30-day supply of medications (to facilitate finding other treatment) or be started on a slow weaning schedule if a decision is made by the physician to terminate prescribing of opioids/controlled substances. Furthermore, a written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent. Patient, guardian, and caregiver attitudes about medicines may influence the patient's use of medications for relief from pain. This type of written document should be obtained prior to initiating opioid therapy. It should be discussed with the patient and family. This plan should be signed and dated and placed in the patient's chart, and include the following: (1) Goals of therapy. (2) Only one provider gives prescriptions. (3) Only one pharmacy dispenses prescriptions. (4) There will be a limit of number of medications, and dose of specific medications. (5) Medications are not to be altered without the prescribing doctor's permission. (6) Heavy machinery and automobile driving is not to occur until drug-induced sedation/drowsiness has cleared. (7) Refills are limited, and will only occur at appointments. (8) Treatment compliance must occur for all other modalities enlisted. (9) Urine drug screens may be required. (10) The patient must acknowledge that they are aware of potential adverse effects of the use of opioids including addiction. (11) Information about opioid management can be shared with family members and other providers as necessary, (12) If opioid use is not effective, the option of discontinuing this therapy may occur. (13) The consequence of non-adherence to the treatment agreement is outlined. In this case, hydrocodone is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated at 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial bases for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant has been on high dose opioids for over a year with no documented improvement in pain scale. There is notation of addiction with no documented weaning program while on 2 other opioids. The use of hydrocodone as disputed above is not medically necessary.