

<b>Case Number:</b>	CM13-0011820		
<b>Date Assigned:</b>	09/24/2013	<b>Date of Injury:</b>	08/25/2010
<b>Decision Date:</b>	03/12/2014	<b>UR Denial Date:</b>	08/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/15/2013

### 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 pain management has a subspecialty in disability evaluation and is licensed to practice in California, maryland, floriday and DC. 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 patient is a 63-year-old male who sustained an injury on 8/25/2010 when he fell while pushing trash. He is diagnosed with leg joint pain and lumbago. He was also diagnosed with right rotator cuff tear. The right shoulder xray dated 9/13/2012 showed cephalad migration of the humeral head nearly complete loss of subacromial space. The right shoulder MR arthrogram dated 4/28/2013 showed chronic complete tear with retraction of the supraspinatus and infraspinatus tendons as well as tendinopathy of the subscapularis and teres minor tendon. The patient also underwent a left total knee arthroplasty on 1/1 8/2013. Other treatments provided include TENS, pain medications, braces/casts, PT, exercise program, acupuncture and chiropractic care. The latest medical report dated 7/2/2013 states that the patient has received appropriate rehabilitation to his knee after the surgery. His current medications are Senna-lax 8.6 mg twice daily, Norco 10-325 mg 2 tablets twice a day, Elavil 15 mg 1 tablet a bedtime, Ambien 5 mg one tablet at bedtime, atenolol 25 mg 1 tablet at bedtime, atorvastatin 20 mg 1 tablet at bedtime, lisinopril 10 mg 1 tablet at bedtime, lisinopril 20 mg 1 tablet at bedtime, Lyrica 150 mg 1 tablet four times a day, Lyrica 75 mg 1 tablet twice a day, nifedipine ER 30 mg 1 tablet at bedtime, orphenadrine 100 mg 1 tablet daily, tizanidine 4 mg 1 to 2 tablets at bedtime, tramadol 50 mg 1 tablet four times a day and theramine 101.5-333.5 mg 1 tablet three times a day. The report states that his pain medications provided little relief of pain. Methadone 5 mg twice a day was then added to his medications. A request is made for Norco, methadone, Elavil and Senna-lax all of which were denied for lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #120 1 tab bid:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines section on Opioids: Norco (hydrocodone) Page(s): s 76-77, 82. Decision based on Non-MTUS Citation ODG-TWC-Pain (Chronic) (updated 11/14/13)-Opioids for chronic pain

**Decision rationale:** With respect to the request for Norco 10/325mg #120 1 tab bid, this is not supported by the guidelines. The medical report states that the pain medications only caused little relief of pain. Significant pain relief and functional improvement as a result of the intake of Norco was not specified to justify the continuation of this medication. The guidelines do not recommend opioid as a first-line treatment for chronic non-malignant pain, and not recommended in patients at high risk for misuse, diversion, or substance abuse. ODG states: Recommended as a 2nd or 3rd line treatment option at doses of 120 mg daily oral morphine equivalent dose (MED). Given that the patient has not had any long-term functional improvement gains from taking Norco over the past several months, it is warranted for the patient to begin weaning from Norco. The guidelines stated that Opioids should be discontinued if there is no overall improvement in function, and they should be continued if the patient has returned to work or has improved functioning and pain. If tapering is indicated, a gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms and 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. It is noted patient was receiving pain medications from 2 providers, second being [REDACTED]. Other than reported levels of pain there is not good rationale for addition of Methadone, or outlined strategy for extinction. It is not clear why 2 months of medication is necessary. Consider an addiction medicine consult if there is evidence of substance misuse. Therefore the request for Norco 10/325mg #120 1 tab bid is not medically necessary.

**Senna laxative 8.6mg 1 tab bid:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid induced Constipation Page(s): 77. Decision based on Non-MTUS Citation ODG-TWC-Pain (Chronic) (Updated 1/7/2014)-Opioid-induced constipation treatment.

**Decision rationale:** Guidelines do- recommend the use of laxatives for patients taking opioids. Given the patient's medication regimen the use of Senna-lax is consistent with the guideline

recommendation. Since Opioid use is deemed not medically necessary, the prescription of laxative Senna is also not medically necessary.

**Elavil 25mg 1 tab qhs:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 12. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), -TWC-Pain (Chronic) (Updated 1/7/2014) Antidepressants for chronic pain.

**Decision rationale:** Regarding the request for Elavil, guidelines recommended anti-depressants as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. However, the latest medical report dated 7/12/13 does not contain a physical examination to demonstrate the presence of neuropathic pain. There is also no indication of depression in this patient. Furthermore, it is noted that he has already been taking Elavil and that this request is for a refill. There are no discussions about the side effects of Elavil in the medical record reviewed. Therefore the request for Elavil 25mg 1 tab qhs is not medically necessary.

**Methadone HCl 5mg #120 1 tab bid:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid-Methadone Page(s): s 61-62. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -TWC-Pain (Chronic) (Updated 1/7/2014) Methadone

**Decision rationale:** Regarding Methadone HCl 5mg #120 1 tab bid the guidelines state that methadone is recommended as a second-line drug for moderate to severe pain if the potential benefit outweighs the risk. There is no evidence that the patient has exhausted or has failed to respond to first-line pain medications to warrant the use of methadone. Also, it appears that the daily Morphine Equivalent Dose of opioid being given to this patient far exceeds the amount recommended by the guidelines. In general, the total daily dose of opioid should not exceed 50mg oral morphine equivalents a decrease from 120mg based on the latest ACOEM recommendation. Rarely, and only after pain management consultation, should the total daily dose of opioid be increased above 120 mg oral morphine equivalents. Recommend that dosing not exceed 120 mg oral morphine equivalents per day, and for patients taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. It is noted patient was receiving pain medications from two providers, second being [REDACTED]. Other than reported levels of pain there is not good rationale for addition of Methadone, or outlined strategy for extinction. It is not clear why 2 months of medication is necessary Therefore, methadone 5 mg #120 is not medically necessary.