MAXIMUS Federal Services

Case Number:	CM14-0202121		
Date Assigned:	12/12/2014	Date of Injury:	06/17/2013
Decision Date:	02/04/2015	UR Denial Date:	11/26/2014
Priority:	Standard	Application Received:	12/03/2014

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. The expert reviewer is Board Certified in Family Practice 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 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/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:

This 57-year-old nursing assistant reported a left shoulder injury after transferring a patient to a bed on June 17, 2013. Despite conservative treatment she has continued to experience shoulder pain. She underwent left arthroscopic acromioplasty and mini open rotator cuff repair in March 2014. Surgery was followed by 24 sessions of physical therapy. Current diagnoses include left shoulder pain and cervicalgia. The patient's primary treater is a chiropractor, who sees her regularly. She is also sees both a surgeon and a pain specialist periodically. Current treatment consists of home exercises, stretching, and ongoing opioid and non-steroidal anti-inflammatory medication. The patient received a cortisone injection to the left shoulder on October 20, 2014. The patient continues to have shoulder and neck pain which is reported to be present 100% of the time by her primary treater. The pain specialist notes that her pain medications improve her ability to perform activities of daily living and provided greater ease of movement by about 50%, but does not give specific examples. The patient has not returned to work. A prescription signed by the surgeon dated December 8, 2014 notes the patient may return to modified work with restrictions if available. However, the patient's primary treater has continued to document that she is at temporary total disability. This patient has been taking Norco since at least 3/31/14. On 5/28/14, she was taking Norco 10/325 four times per day. On 7/24/14 her dosage was decreased to Norco 10/325 three times per day, where it has been ever since. There is some question about whether or not she is also taking tramadol. Her providers either don't document her medications or document that she is taking meloxicam and Norco. However, there are several drug screens in the records that document that she is taking both Norco and tramadol. They are all reported as inconsistent because the results are negative for tramadol. None of her providers have addressed this issue. On 11/19/14 the pain specialist requested authorization for Norco 10/325 mg every 8 hours as needed, maximum 3 tablets per day, #90.On November 26,

2014 the Utilization Review denied certification for Norco 10/325 mg #90. Citations used in the decision process were the Medical Treatment Utilization Schedule (MTUS) Chronic Pain Guidelines on opioids.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO10/325 MG ONE BY MOUTH EVERY 8 HOURS AS NEEDED, MAX 3/DAY, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, Criteria for Use of Opioids, Steps to Take Before a Therapeutic Tr.

Decision rationale: Norco 10/325 is brand-name hydrocodone 10 mg with acetaminophen 325 mg. Hydrocodone is an opioid analgesic. Per the MTUS recommendations cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it.Opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine if the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Opioids should be discontinued if there is no improvement in function. There is no good evidence that opioids are effective for radicular pain. If long-term use of opioids occurs, there is a need for ongoing pain and function assessments, as well as assessments for side effects, of concurrent other treatments, and of concurrent psychological issues.The clinical findings in this case do not demonstrate that any of the above criteria have been met. This patient has been prescribed Norco since at least 3/31/14. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. No assessment is documented of whether or not opioid use was likely to be helpful in this patient, or of her potential for abuse. It is quite concerning that several urine drug screens have been negative for tramadol (another opioid which the patient is documented as taking) during the past year, which should have raised concerns about diversion. No specific functional goals were set or followed. Most importantly, Norco was not discontinued when it became clear that it has not produced any functional improvement. The patient's status has remained at totally disabled, which implies that she has profound disabilities and inability to do even the lightest sedentary work. Based on the evidence-based guidelines cited above, and the clinical documentation provided for my review, Norco 10/325 #90 is not medically necessary. It is not medically necessary because of the lack of appropriate documentation of the patient's status prior to beginning it, because of the failure to set and monitor functional goals, because negative drug screens should have raised concerns about diversion that have not been addressed, and because of the failure to discontinue it when it became clear that it has not produced any functional recovery.