MAXIMUS Federal Services

| Case Number: | CM14-0217920 | | |
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| Date Assigned: | 01/07/2015 | Date of Injury: | 11/06/2006 |
| Decision Date: | 02/28/2015 | UR Denial Date: | 12/01/2014 |
| Priority: | Standard | Application Received: | 12/29/2014 |

## 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. 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 71 year old male with a date of injury as 11/06/2006. The cause of the injury occurred when the worker was throwing a garbage can into a dumpster. The current diagnoses include right shoulder internal derangement, right carpal tunnel syndrome, right median neuropathy, right median epicondylitis, myofascial pain syndrome, history of right shoulder rotator cuff injury with tear, status post right shoulder rotator cuff repair on 09/11/2008, and flare-up of right shoulder pain. Previous treatments include oral and topical medications, rotator cuff repair in 05/2007 and 09/2008, home exercise program, physical therapy, psychotherapy, and TENS unit. Primary treating physician's reports dated 07/14/2014 through 01/07/2015, psychiatric evaluations dated 06/06/2014 through 01/23/2015, comprehensive neurological consultation dated 10/28/2014, and urine drug screenings dated 07/14/2014 and 10/15/2014 were included in the documentation submitted for review. Report dated 01/07/2015 noted that the injured worker presented with complaints that included ongoing pain in the right shoulder. Physical examination revealed right shoulder tenderness with painful range of motion, decreased range of motion, and decreased strength on the right. The physician noted that the Vimovo was to be discontinued and the injured worker was start a trial of Zorvolex. Documentation supports that the injured worker is currently using Norco up to 2 tablets a day for pain control. Documentation from 09/16/2014 notes that the injured worker was previously using Norco 3 times per day, and topical ketoprofen cream, Zanaflex, and Duexis were discontinued as they were not providing any relief. Urine drug screenings performed on 07/14/2014 and 10/15/2014 were negative for hydrocodone. The injured worker's work status was not included.

The utilization review performed on 12/01/2014 partially-certified a prescription for Norco based on no evidence to support objective functional improvement with the use of this medication as well as no documentation of current urine drug screenings, risk assessment profile, attempt at weaning/tapering, or an updated signed pain contract. Request for Vimovo was non-certified based on no documentation to support trial and failure of first-line proton pump inhibitors. The reviewer referenced the California MTUS and Official Disability Guidelines in making this decision.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg, #90:** Upheld

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

**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: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 membersor other caregivers should be considered in determining the patient's response totreatment. 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 therapeuticdecisions and provide a framework for documentation of the clinical use of thesecontrolled drugs. (Passik, 2000)(d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain dairy 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 drugescalation, drug diversion).(g) Continuing review of overall situation with regard to nonopioid means of paincontrol.(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 us of this medication is not recommended unless certain objective outcome measures have been met as defined above. There is no provided objective outcome measure that shows significant improvement in function while on the medication. There is no evidence of failure of other conservative treatment modalities and other first line choices for chronic pain. There is no documentation of significant improvement in VAS scores while on the medication. For these reasons criteria for ongoing and continued use of the medication have not been met. Therefore the request is not certified.

**Vimovo 500/20mg, #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary last updated 1/30/2014 Vimovo

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 68.

**Decision rationale:** The California chronic pain medical treatment guidelines section on NSAID therapy and proton pump inhibitors (PPI) states:Recommend with precautions as indicated below.Clinicians should weight the indications for NSAIDs against both GI and cardiovascular riskfactors.Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or a anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastro duodenal lesions.RecommendationsPatients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g,ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease:(1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary.There is no documentation provided that places this patient at intermediate or high risk that would justify the use of a PPI with an NSAID either seperately or in a fixed dose combination. Therefore the request is not certified.