

Case Number:	CM15-0202206		
Date Assigned:	10/19/2015	Date of Injury:	05/09/2004
Decision Date:	11/25/2015	UR Denial Date:	10/07/2015
Priority:	Standard	Application Received:	10/14/2015

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: Colorado

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 62 year old male, who sustained an industrial injury on 5-9-2004. The injured worker is undergoing treatment for: shoulder pain. On 8-25-15, he reported left shoulder pain. His pain rating with medications is 7/10 and without medications 9/10. His activities of daily living are noted as his being able to cook, do laundry, bathe, dress, drive. Physical examination revealed limited motion with pain of the upper extremities. On 9-22-15, he reported left shoulder pain rated 5/10 with medications and 10/10 without medications. He is noted as being able to cook, bathe, dress, and drive. Physical examination revealed a regular rate and rhythm without murmur of the cardiovascular system. There is no documentation of examination of the left shoulder. The treatment and diagnostic testing to date has included: medications, pain contract, and MRI. Medications have included: Ibuprofen, Neurontin, and Norco. The records indicate he has been utilizing Norco since at least May 2011, possibly longer. Current work status: off work, permanently disabled. The request for authorization is for: Norco 10-325mg quantity #180. The UR dated 10-7-15: non-certified the request for Norco 10-325mg quantity 180.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, long-term assessment, Opioid hyperalgesia, Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, specific drug list.

Decision rationale: The Guidelines establish criteria for use of opioids, including long-term use (6 months or more). When managing patients using long-term opioids, the following should be addressed: Re-assess the diagnosis and review previous treatments and whether or not they were helpful. When re-assessing, pain levels and improvement in function should be documented. Pain levels should be documented every visit. Function should be evaluated every 6 months using a validated tool. Adverse effects, including hyperalgesia, should also be addressed each visit. Patient's motivation and attitudes about pain/work/interpersonal relationships can be examined to determine if patient requires psychological evaluation as well. Aberrant/addictive behavior should be addressed if present. Do not decrease dose if effective. Medication for breakthrough pain may be helpful in limiting overall medication. Follow up evaluations are recommended every 1-6 months. To summarize the above, the 4A's of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors) have been established. 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) Several circumstances need to be considered when determining to discontinue opioids: 1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of opioids. 2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to opioids, and aggressive or threatening behavior in clinic. Weaning from the medication over 30 day period, under direct medical supervision, is recommended unless a reason for immediate discontinuation exists. If a medication contract is in place, some physicians will allow one infraction without immediate discontinuation, but the contract and clinic policy should be reviewed with patient and consequences of further violations made clear to patient. 3) Consider discontinuation if there has been no improvement in overall function, or a decrease in function. 4) Patient has evidence of unacceptable side effects. 5) Patient's pain has resolved. 6) Patient exhibits "serious non-adherence". Per the Guidelines, Chelminski defines "serious substance misuse" or non-adherence as meeting any of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for substances not routinely prescribed. (Chelminski, 2005) 7) Patient requests discontinuing opioids. 8) Consider verifying that patient is in consultation with physician specializing in addiction to consider detoxification if patient continues to violate the medication contract or shows other signs of abuse/addiction. 9) Document the basis for decision to discontinue opioids. Likewise, when making the decision to continue opioids long term, consider the following: Has patient returned to work? Has patient had improved function and decreased pain with the opioids? For the patient of concern, it is documented that patient's pain is constant, sharp and aching, but improved with medication regimen, which includes Norco. (Pain rating

5/10 with medications and 10/10 without medications at recent visit.) However, also noted at most recent visit September 22, 2015, patient was advised by a primary care provider to discontinue opiates, and pain management provider documented support for discontinuation, but with weaning. ADL's were discussed at each visit, but the documentation is unclear as to the objective improvement of function and no clinically validated tool for assessment of function was documented. Urine drug screen in last 6 months was consistent with medications. Side effects and aberrant behaviors were denied per patient, though no details on the discussion were provided. Records indicate patient is permanently disabled. Though patient does have the majority of the 4A's documented, he does not have documentation of objective assessment of / improvement in function, so the request for Norco is not medically necessary.