

<b>Case Number:</b>	CM15-0030839		
<b>Date Assigned:</b>	02/24/2015	<b>Date of Injury:</b>	01/04/2002
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	02/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2015

### 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 65 year old female with an industrial injury dated 1/4/2002. The injured worker diagnoses include bilateral shoulder disorder, unspecified, cervicalgia, cervical radiculopathy and cervical spinal stenosis. She has been treated with diagnostic studies, physical therapy, cervical fusion 7/28/2014, and bilateral shoulder surgeries, medications and periodic follow up visits. According to the progress notes dated 1/5/2015 and 2/9/2015, the injured worker reported bilateral shoulder pain and neck pain. The treating physician noted well healed post-surgical incision over the right anterior cervical region. There was persistent decreased range of motion with pain in the cervical spine. The treating physician prescribed refill of Hydrocodone/APAP 7.5/325 #60 now under review. Utilization Review determination on February 5, 2015 modified the request to Hydrocodone/APAP 7.5/325 #30, citing MTUS, ACOEM Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydroco/APAP 7.5/325 #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 79-80, 85, 88-89, 91, 94.

**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) Monitoring should include "frequent and random" urine drug screens for high risk opioid patients. 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 opioids 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? Per the records supplied for review, the patient of concern has had reduced pain with long term Hydrocodone/APAP in addition to his other medications, with pain ratings 6/10 on medications and 9/10 without medications as of 2/9/2015 clinic visit. The notes also indicate patient has improved function, but there is no objective evidence that patient medications improved function. The records include pain related impairment measurements which are only slightly improved over the last year (54-49), a year that has also included physical therapy

and surgery which could certainly be related to the slight improvement in function. No significant improvement in pain related impairment is noted on the last 2 visits when completed (when only medications would be affecting function). While the records include extensive discussion of the need for urine drug screens and the fact that patient is high risk for opioid abuse, there is only 1 urine drug screen available in the records, and it is dated 7/2013. This would not be considered frequent testing as would be recommended for patient at high risk for aberrant drug taking behavior. As above, the records do not establish objective evidence of improved function due to Hydrocodone/APAP, and do not include appropriate monitoring of patient's opioid use. Therefore, the Hydrocodone/APAP is no longer medically indicated for patient.