

ReviewTex. Inc.
1818 Mountjoy Drive
San Antonio, TX 78232
(phone) 210-598-9381 (fax) 210-598-938
reviewtex@hotmail.com

Date notice sent to all parties:

April 19, 2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

MED Appeal HYDROCO/APAP TAB 10-325MG Day Supply:30 Qty: 180 Refills: 00

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on XX/XX/XX. The patient is noted to have had a prior lumbar fusion and has been followed for chronic complaints of pain. The patient has a long history of narcotics use as far back as XXXX. The patient was being followed for pain management. The prior medications included hydrocodone 10/325mg. Other medications included Tizanidine and duloxetine. As of XX/XX/XX the patient had recently undergone trigger point injections. The patient had not utilized hydrocodone for one month. After hydrocodone was discontinued the patient did not have overt withdrawal symptoms but described increase in pain in the feet and left thigh. The patient also indicated a reduction in functional capacity without hydrocodone as well as severe pain 10/10 in intensity. With medications the patient described 40% pain relief with pain scores 6/10 in intensity. Without medications the patient's pain was 10/10. Physical examination noted weakness in the lower extremities at the tibialis anterior with absent reflexes. It is noted that the patient was able to reduce hydrocodone from six pills per day to three pills per day but still obtained functional improvement and pain reduction.

The patient had not returned to work but was able to perform normal activities of daily living with the use of hydrocodone. Urine drug screen samples were obtained.

Hydrocodone was found not medically necessary on XX/XX/XX as there was no established documentation regarding increase in pain increase in function or decrease in pain as well as lack of documentation regarding screening exams for misuse. The requested hydrocodone was again denied on XX/XX/XX due to limited evidence regarding functional improvement or pain reduction as well as documentation regarding urine drug screens or other assessments for opioid risk.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The clinical records submitted for review discussed the efficacy of hydrocodone when it was being utilized. Per records the patient was obtaining up to 40% relief with the use of hydrocodone with pain scores being reduced from 10/10 to 6/10. The patient was noted to be reducing hydrocodone to 10mg three times a day instead of six per day. Even with the reduction the patient was still indicating functional improvement and pain reduction. XX records indicated no aberrant behaviors. The patient had urine drug screen samples taken as of 220's as of the XX/XXXX evaluation. The patient also described functional improvement improvements with activities of daily living while utilizing hydrocodone. In this case this reviewer does feel that hydrocodone has been established as medically necessary as there is functional improvement and pain reduction. The patient was continuing to obtain urine drug screen tests for compliance. However, the records indicate the patient was able to obtain appropriate pain relief with hydrocodone 10/325mg up to three times per day. Therefore, it is this reviewer's opinion that medical necessity is only established for hydrocodone 10/325mg quantity 90. It is this reviewer's opinion that the requested hydrocodone at 10/325mg #180 is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines (ODG), Treatment Index, 14th Edition (web), 2016, Pain Chapter.

CRITERIA FOR USE OF OPIOIDS

Therapeutic Trial of Opioids

1) Establish a Treatment Plan. The use of opioids should be part of a treatment plan that is tailored to the patient. Questions to ask prior to starting therapy:

(a) Are there reasonable alternatives to treatment, and have these been tried?

(b) Is the patient likely to improve? Examples: Was there improvement on opioid treatment in the acute and subacute phases? Were there trials of other treatment, including non-opioid medications?

(c) Has the patient received a screen for the risk of addiction? Is there likelihood of abuse or an adverse outcome? Specific questions about current use of alcohol, illegal drugs, other prescription drugs, and over-the counter drugs should be asked. Obtaining a history of personal and/or family substance abuse issues is important. See [Substance abuse \(tolerance, dependence, addiction\)](#). See [Opioids, screening for risk of addiction](#). ([Webster, 2008](#)) ([Ballyantyne, 2007](#))

(d) Ask about Red Flags indicating that opioids may not be helpful in the chronic phase: (1) Little or no relief with opioid therapy in the acute and subacute phases. (2) The patient has been given a diagnosis in one of the particular diagnostic categories that have not been shown to have good success with opioid therapy: conversion disorder; somatization disorder; pain disorder associated with psychological factors (such as anxiety or depression, or a previous history of substance abuse). Patients may misuse opioids prescribed for pain to obtain relief from depressed feelings, anxiety, insomnia, or discomforting memories. There are better treatments for this type of pathology. ([Sullivan, 2006](#)) ([Sullivan, 2005](#)) ([Wilsey, 2008](#)) ([Savage, 2008](#))

(e) When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, physicians and surgeons who make a clinical decision to withhold opioid medications should document the basis for their decision.

2) Steps to Take Before a Therapeutic Trial of Opioids:

(a) Attempt to determine if the pain is nociceptive or neuropathic. Also attempt to determine if there are underlying contributing psychological issues. Neuropathic pain may require higher doses of opioids, and opioids are not generally recommended as a first-line therapy for some neuropathic pain.

(b) A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics.

(c) Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals.

(d) Baseline pain and functional assessments should be made. Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale. See Function Measures.

(e) Pain related assessment should include history of pain treatment and effect of pain and function.

(f) Assess the likelihood that the patient could be weaned from opioids if there is no improvement in pain and function.

(g) The patient should have at least one physical and psychosocial assessment by the treating doctor (and a possible second opinion by a specialist) to assess whether a trial of opioids should occur. When subjective complaints do not correlate with imaging studies and/or physical findings and/or when psychosocial issue concerns exist, a second opinion with a pain specialist and a psychological assessment should be obtained. ([Sullivan, 2006](#)) ([Sullivan, 2005](#)) ([Wilsey, 2008](#)) ([Savage, 2008](#)) ([Ballyantyne, 2007](#))

(h) The physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian.

(i) A written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent. Patient, guardian, and caregiver attitudes about medicines may influence the patient's use of medications for relief from pain. See [Guidelines for Pain Treatment Agreement](#). This should include the consequences of non-adherence.

(j) Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs.

3) Initiating Therapy

(a) Intermittent pain: Start with a short-acting opioid trying one medication at a time.

(b) Continuous pain: extended-release opioids are recommended. Patients on this modality may require a dose of "rescue" opioids. The need for extra opioid can be a guide to determine the sustained release dose required.

(c) Only change 1 drug at a time.

(d) Prophylactic treatment of constipation should be initiated.

(e) If partial analgesia is not obtained, opioids should be discontinued.

4) 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 members or other caregivers should be considered in determining the patient's response to treatment. *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 nonadherent) 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 therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. ([Passik, 2000](#))

(d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary 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. ([Webster, 2008](#))

(f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion).

(g) Continuing review of overall situation with regard to nonopioid means of pain control.

(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. ([Sullivan, 2006](#)) ([Sullivan, 2005](#)) ([Wilsey, 2008](#)) ([Savage, 2008](#)) ([Ballyantyne, 2007](#))

5) Recommended Frequency of Visits While in the Trial Phase (first 6 months):

- (a) Every 2 weeks for the first 2 to 4 months
- (b) Then at approximate 1 ½ to 2-month intervals

Note: According to the California Medical Board Guidelines for Prescribing Controlled Substances for Pain, patients with pain who are managed with controlled substances should be seen monthly, quarterly, or semiannually as required by the standard of care. ([California, 1994](#))

6) When to Discontinue Opioids: See [Opioid hyperalgesia](#). Also see [Weaning of Medications](#). Prior to discontinuing, it should be determined that the patient has not had treatment failure due to causes that can be corrected such as under-dosing or inappropriate dosing schedule. Weaning should occur under direct ongoing medical supervision as a slow taper except for the below mentioned possible indications for immediate discontinuation. The patient should not be abandoned.

- (a) If there is no overall improvement in function, unless there are extenuating circumstances
- (b) Continuing pain with the evidence of intolerable adverse effects; lack of significant benefit (persistent pain and lack of improved function despite high doses of opiates- e.g. > 100 mg/day morphine equivalents)
- (c) Decrease in functioning
- (d) Resolution of pain
- (e) If serious non-adherence is occurring
- (f) The patient requests discontinuing
- (g) Immediate discontinuation has been suggested for: evidence of illegal activity including diversion, prescription forgery, or stealing; the patient is involved in a motor vehicle accident and/or arrest related to opioids, illicit drugs and/or alcohol; intentional suicide attempt; aggressive or threatening behavior in the clinic. It is suggested that a patient be given a 30-day supply of medications (to facilitate finding other treatment) or be started on a slow weaning schedule if a decision is made by the physician to terminate prescribing of opioids/controlled substances.
- (h) Many physicians will allow one “slip” from a medication contract without immediate termination of opioids/controlled substances, with the consequences being a re-discussion of the clinic policy on controlled substances, including the consequences of repeat violations.

(i) If there are repeated violations from the medication contract or any other evidence of abuse, addiction, or possible diversion it has been suggested that a patient show evidence of a consult with a physician that is trained in addiction to assess the ongoing situation and recommend possible detoxification. ([Weaver, 2002](#))

(j) When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, physicians and surgeons who make a clinical decision to withhold opioid medications should document the basis for their decision.

(k) Routine long-term opioid therapy is not recommended, and ODG recommends consideration of a one-month limit on opioids for new chronic non-malignant pain patients in most cases, as there is little research to support use. The research available does not support overall general effectiveness and indicates numerous adverse effects with long-term use. The latter includes the risk of ongoing psychological dependence with difficulty weaning. See [Opioids for chronic pain](#).

7) When to Continue Opioids

(a) If the patient has returned to work

(b) If the patient has improved functioning and pain