

Case Number:	CM13-0040155		
Date Assigned:	12/20/2013	Date of Injury:	09/22/2001
Decision Date:	03/26/2014	UR Denial Date:	10/01/2013
Priority:	Standard	Application Received:	10/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine 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 physician 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:

The claimant is a 53-year-old male with a date of injury of 9/22/2001. The claimant complains of neck, mid-back, low-back and left elbow pain with left leg symptoms including numbness extending to the knee. The pain is rated 8.5/10. The examination findings include tenderness to palpation of the lumbar spine, sacroiliac joint, and piriformis muscle with flexion and extension, myofascial spasms of the quadratus lumborum with flexion and extension. The LasA"gue's test is negative, motor strength 4.5/5 in the left lower extremity, and 5/5 in the right lower extremity. Deep tendon reflexes are decreased in the bilateral knees and ankles, no acute distress, mildly antalgic gait, cervical and lumbar spine ranges of motion decreased in all planes, and decreased sensation of the left C6, C7, C8, L4, L5, and S1 dermatomes. The MRI of the lumbar spine dated 3/15/2013, included impressions of levoscoliosis with disc abnormality and facet arthropathy with retrolisthesis at L5-S1, canal stenosis L4-5 mild to moderate, neural foraminal narrowing L3-4 moderate right and moderate to severe left, L4-5 severe left, moderate to severe right, and L5-S1 severe bilaterally. The diagnoses include: 1) post lumbar laminectomy syndrome with M/L severe stenosis and left lumbosacral radiculopathy; 2) lumbar facet arthropathy; 3) rheumatoid arthritis; and 4) left lumbar radiculopathy. Treatment has consisted of medications including Oxycontin, Dilaudid, Flexeril, Lidoderm, folic acid, methotrexate, prednisone, and Humira pen. Medications partly help manage pain and are positive for activities of daily living. The claimant is also experiencing increased pain in the morning attributed to a worn out mattress.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) replacement bed to help support the back: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic).

Decision rationale: The Official Disability Guidelines indicate that mattress selection is "Not recommended to use firmness as sole criteria. In a recent RCT, a waterbed (Agva) and a body contour foam mattress (Tempur) generally influenced back symptoms, function, and sleep more positively than a hard mattress, but the differences were small. The dominant problem in this study was the large amount of dropouts. The predominant reason for dropping out before the trial involved the waterbed, and there was some prejudice towards this type of mattress. The hard mattress had the largest amount of test persons who stopped during the trial due to worsening LBP, as users were more likely to turn around in the bed during the night because of pressures on protruding body parts. Another clinical trial concluded that patients with medium-firm mattresses had better outcomes than patients with firm mattresses for pain in bed, pain on rising, and disability; a mattress of medium firmness improves pain and disability among patients with chronic non-specific low-back pain. There are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. Mattress selection is subjective and depends on personal preference and individual factors. On the other hand, pressure ulcers (e.g., from spinal cord injury) may be treated by special support surfaces (including beds, mattresses and cushions) designed to redistribute pressure." The Official Disability Guidelines do not support the purchase of a mattress as treatment for low back pain. The request for one (1) replacement bed to help support back is determined to not be medically necessary, and does not meet guideline recommendations.

Oxycontin 80mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section Page(s): s 42, 80, 86.

Decision rationale: The treating provider has not provided sufficient documentation to indicate that Oxycontin has improved function. The Chronic Pain Guidelines indicate that opioids "appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56% (a statistic limited

by poor study design). Limited information indicated that up to one-fourth of patients who receive opioids exhibit aberrant medication-taking behavior." Additionally, the guidelines indicate that the time to continue opioid treatment is "(a) If the patient has returned to work (b) If the patient has improved functioning and pain." The treating provider has not indicated that either of these conditions are being achieved with the use of opioid medical treatment. The guidelines also indicate that opioid dosing is "Recommend that dosing not exceed 120 mg oral morphine equivalents per day, and for patients taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. Use the appropriate factor below to determine the Morphine Equivalent Dose (MED) for each opioid. In general, the total daily dose of opioid should not exceed 120 mg oral morphine equivalents. Rarely, and only after pain management consultation, should the total daily dose of opioid be increased above 120 mg oral morphine equivalents. There are other guidelines to consider, and actual maximum safe dose will be patient-specific and dependent on current and previous opioid exposure, as well as on whether the patient is using such medications chronically. When using single-agent opioid preparations, the dose should be slowly escalated until adequate pain relief is seen or side effects preclude further escalation." The morphine equivalent dosing is 360 mg per day (Oxycontin alone) and total prescribed MED is 456 mg per day, which is much higher than the recommended ceiling of 120 mg per day. There is no evidence provided by the treating provider to indicate that continued long-term use of opioids for pain management is medically necessary, and the Chronic Pain Medical Treatment Guidelines do not support continuous use of opioids. It is important, however, to not abruptly discontinue use without a plan for detoxification. According to the guidelines, "detoxification is defined as withdrawing a person from a specific psychoactive substance, and it does not imply a diagnosis of addiction, abuse or misuse. May be necessary due to the following: (1) Intolerable side effects, (2) Lack of response, (3) Aberrant drug behaviors as related to abuse and dependence, (4) refractory comorbid psychiatric illness, or (5) Lack of functional improvement. Gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms." There are different strategies for the discontinuation of opioids, which could include the use of Oxycontin at a tapering dose and/or frequency. The current request; however is for continued pain management, not for detoxification. It is determined that the request for Oxycontin 80 mg #90 is not medically necessary.

Dilaudid 4mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section Page(s): s 42, 80, 86.

Decision rationale: The treating provider has not provided sufficient documentation to indicate that Dilaudid has improved function. The Chronic Pain Guidelines indicate that opioids for chronic back pain, "appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56% (a statistic limited by poor study design). Limited information indicated that up to one-fourth of patients who receive opioids exhibit aberrant medication-taking behavior." Additionally, the guidelines indicate that the time to continue opioid treatment is: "(a) If the patient has returned to

work (b) If the patient has improved functioning and pain." The treating provider has not indicated that either of these conditions is being achieved with the use of opioid medical treatment. The guidelines also indicate that opioid dosing is "Recommend that dosing not exceed 120 mg oral morphine equivalents per day, and for patients taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. Use the appropriate factor below to determine the Morphine Equivalent Dose (MED) for each opioid. In general, the total daily dose of opioid should not exceed 120 mg oral morphine equivalents. Rarely, and only after pain management consultation, should the total daily dose of opioid be increased above 120 mg oral morphine equivalents. There are other guidelines to consider, and actual maximum safe dose will be patient-specific and dependent on current and previous opioid exposure, as well as on whether the patient is using such medications chronically. When using single-agent opioid preparations, the dose should be slowly escalated until adequate pain relief is seen or side effects preclude further escalation." The morphine equivalent dosing is 96 mg per day (Dilaudid alone) and total prescribed MED is 456 mg per day, which is much higher than the recommended ceiling of 120 mg per day. There is no evidence provided by the treating provider to indicate that the continued long-term use of opioids for pain management is medically necessary, and the guidelines do not support continuous use of opioids. It is important, however, to not abruptly discontinue use without a plan for detoxification. Per these guidelines, "detoxification is defined as withdrawing a person from a specific psychoactive substance, and it does not imply a diagnosis of addiction, abuse or misuse. May be necessary due to the following: (1) Intolerable side effects, (2) Lack of response, (3) Aberrant drug behaviors as related to abuse and dependence, (4) refractory comorbid psychiatric illness, or (5) Lack of functional improvement. Gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms." There are different strategies for the discontinuation of opioids, which could include the use of Dilaudid at a tapering dose and/or frequency. The current request however is for continued pain management, not for detoxification. It is determined that the request for Dilaudid 4 mg #180 is not medically necessary.

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