

<b>Case Number:</b>	CM14-0137400		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	10/24/1995
<b>Decision Date:</b>	10/06/2014	<b>UR Denial Date:</b>	07/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2014

### 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. The expert reviewer is Board Certified in Family 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 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/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:

This is a female patient who reported an industrial injury on 10/24/1995, almost 19 years ago, attributed to the performance of her usual and customary job tasks reported as transferring a patient and perceiving back pain. The patient was being treated for the diagnoses of lumbago; meningitis; post laminectomy syndrome lumbar; anxiety; and chronic pain. The patient was noted to have pain relief with an intra-thecal pump. The patient complained of persistent neck and back pain. The patient was being treated for the additional diagnoses of lumbar arachnoiditis; status post cervical fusion; bilateral carpal tunnel syndrome status post bilateral CTR and chronic pain syndrome. The patient was prescribed Opana ER 20 mg; Dilaudid 4 mg; Ondansetron; Benazepril 20 mg; Premarin; Omeprazole; Clonidine; Amitriptyline; Soma 350 mg; Xanax; and Inderal LA. The patient was increased to 30 mg Q 12 hours of Opana ER on 8/25/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydromorphone Tab 4mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines opioids Page(s): 74-97. Decision

**Decision rationale:** The prescription for Hydromorphone/Dilaudid 4 mg #30 for short acting pain is being prescribed as an opioid analgesic for the treatment of chronic pain to the neck and back post operatively for the date of injury 19 years ago. The objective findings on examination do not support the medical necessity for continued opioid analgesics. The patient is being prescribed opioids for reported chronic pain, which is inconsistent with the recommendations of the CA MTUS. There is no objective evidence provided to support the continued prescription of opioid analgesics for the cited diagnoses and effects of the industrial claim. The patient should be titrated down and off the prescribed Hydromorphone/Dilaudid 4 mg. The patient is 19 years s/p DOI with reported continued issues. There is no demonstrated medical necessity for the continuation of opioids for the effects of the industrial injury. The chronic use of Hydrocodone-APAP is not recommended by the CA MTUS, the ACOEM Guidelines, or the Official Disability Guidelines for the long-term treatment of chronic back and neck postoperative pain. The prescription of opiates on a continued long-term basis is inconsistent with the CA MTUS and the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic back/neck pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs for the treatment of chronic pain. The current prescription of opioid analgesics is inconsistent with evidence-based guidelines. The prescription of opiates on a continued long-term basis is inconsistent with the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs for the treatment of chronic pain issues. Evidence-based guidelines necessitate documentation that the patient has signed an appropriate pain contract, functional expectations have been agreed to by the clinician, and the patient, pain medications will be provided by one physician only, and the patient agrees to use only those medications recommended or agreed to by the clinician to support the medical necessity of treatment with opioids. The ACOEM Guidelines updated chapter on chronic pain states, "Opiates for the treatment of mechanical and compressive etiologies: rarely beneficial. Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (70 days). This leads to a concern about confounding issues; such as, tolerance, opioid-induced hyperalgesia, long-range adverse effects, such as, hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect." ACOEM guidelines state that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal symptoms; they should be used only if needed for severe pain and only for a short time. The long-term use of opioid medications may be considered in the treatment of chronic musculoskeletal pain, if: The patient has signed an appropriate pain contract; Functional expectations have been agreed to by the clinician and the patient; Pain medications will be provided by one physician only; The patient agrees to use only those medications recommended or agreed to by the clinician. ACOEM also notes, "Pain medications are typically not useful in the subacute and chronic phases and have been shown to be the most important factor impeding recovery of function." There is no clinical documentation by with objective findings on examination to support the medical necessity of Hydrocodone-APAP for this long period of time or to support ongoing functional improvement. There is no provided evidence that the patient has received benefit or demonstrated functional

improvement with the prescribed Hydrocodone-APAP. There is no demonstrated medical necessity for the prescribed Opioids. The continued prescription for Hydromorphone/Dilaudid 4 mg #30 is not demonstrated to be medically necessary.