

<b>Case Number:</b>	CM14-0020434		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	05/22/2000
<b>Decision Date:</b>	09/30/2014	<b>UR Denial Date:</b>	01/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2014

### 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 Anesthesia, has a subspecialty in Acupuncture and Pain 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:

55y/o male injured worker with date of injury 5/22/00 with related back pain. Per progress report dated 1/15/14, he rated his pain 3/10 in intensity. It was noted that he had moved past his prolonged period of depression that he had going back 2 to 3 years and seemed to be very active. He had a very good regimen with his 7 days-a-week exercise and understood the importance of stretching and he had psychologically and emotionally been in a very good place. He was working full time. The PTP noted that he and the injured worker were still looking at a long-term process of minimizing or getting off chronic opioid therapy. There was a desire on behalf of the injured worker to do something like this. The PTP noted that he was not endorsing this as a plan because of any addiction behaviors with the patient, but because of the long-term exposure and possibility of possible hyperalgesia, even though the injured worker had a long history of taking his medications appropriately. The injured worker was very clear that the opioid therapy still suppressed his overall daily pain level to the point where even though it was still existent, he was able to work and do things. It was noted that he had a slight decrease in his opioid 3 months ago and it was a little transition time for him, but otherwise, he had made it through that, since he was doing well and again was continuing to work on strengthening and stretching and all of the appropriate skills and lifestyle changes that benefit his back long term. The date of UR decision was 1/24/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydromorphone tablets 4mg: days supply: 30; quantity: 120 to permit weaning of total opioid dose to 120 mg med:** Overtuned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 98,76,86,89,124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Weaning of Medications Page(s): 124.

**Decision rationale:** Per MTUS Chronic Pain Medical Treatment Guidelines with regard to weaning of medications: Recommended as indicated below. Opioids: For opioids a slow taper is recommended. The longer the patient has taken opioids, the more difficult they are to taper. The process is more complicated with medical comorbidity, older age, female gender, and the use of multiple agents. Gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms. (Benzon, 2005) Patients with complex conditions with multiple comorbidities (including psych disorders) should be referred to an addiction medicine/psychiatry specialist. Opioid weaning should include the following: (a) Start with a complete evaluation of treatment, comorbidity, psychological condition; (b) Clear written instructions should be given to the patient and family; (c) If the patient can not tolerate the taper, refer to an expert (pain specialist, substance abuse specialist); (d) Taper by 20 to 50% per week of original dose for patients who are not addicted (the patient needs 20% of the previous day's dose to prevent withdrawal); (e) A slower suggested taper is 10% every 2 to 4 weeks, slowing to a reductions of 5% once a dose of 1/3 of the initial dose is reached; (f) Greater success may occur when the patient is switched to longer-acting opioids and then tapered; (g) Office visits should occur on a weekly basis; (h) Assess for withdrawal using a scale such as the Subjective Opioid Withdrawal Scale (SOWS) and Objective Opioid Withdrawal Scale (OOWS); & (i) Recognize that this may take months. As the injured worker's use of OxyContin and hydromorphone is in excess of the MTUS recommended 120 MED, weaning is appropriate. The request is medically necessary.