

Case Number:	CM14-0033497		
Date Assigned:	03/21/2014	Date of Injury:	10/28/1993
Decision Date:	04/28/2014	UR Denial Date:	03/05/2014
Priority:	Standard	Application Received:	03/17/2014

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 Physical Medicine & Rehabilitation and Pain Medicine and is licensed to practice in Texas and Ohio. 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:

The patient is a 58-year-old male who reported an injury on 10/28/1993. The mechanism of injury was a fall. His initial injuries included soft tissue injuries to his right knee, lower back, neck, and right shoulder. However, the patient developed numbness and decreased ankle reflex in the lower limb, and was suspected of having a lumbosacral radiculopathy. The patient initially responded to conservative treatment and was able to utilize pain medications on an as needed basis. The patient had a severe exacerbation of his Crohn's disease that hospitalized him and resulted in at least 5 abdominal surgeries. Due to this period of illness, the patient experienced an extreme deconditioning and exacerbation of pain. Due to the patient's multiple co-morbidities, he developed a tolerance for his pain medications, and despite attempts at weaning, the patient continued to complain of pain and sought multiple physicians for prescriptions of pain medications. The patient's current medication regimen includes OxyContin 80 mg every 8 hours; oxycodone 30 mg every 4 hours as needed, max 8 per day; Percocet 10/325 mg 3 times a day; Marinol 5 mg 3 times a day; and Nexium 40 mg daily. Despite the patient's heavy opioid use, he continues to complain of excruciating, debilitating pain. The most recent clinical note dated 02/11/2014 did not provide any objective pain levels, ranges of motion, or neurologic findings. It was noted that, due to the patient's severe central canal stenosis and neural foraminal stenosis in the cervical spine, an orthopedic evaluation was requested. In addition, due to the patient's complaints of numbness to the left side, an EMG/NCS was obtained; however, results of this test were not included for review. There was no other information submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

OXYCONTIN 80MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS
Page(s): 74-95.

Decision rationale: California MTUS/ACOEM Practice Guidelines recommend opioids to treat moderate to severe chronic pain. In assessing the efficacy of opioid therapy, it is recommended that physicians obtain thorough pain assessments at each clinical visit, functional measurements at 6 month intervals using a numerical scale or validated instrument, and perform frequent random urine drug screens to monitor patient compliance. Pain assessment should include the patient's current pain levels, the least reported pain since the last assessment, average pain levels, intensity of pain after taking the opioid, how long it takes for pain relief to begin, and how long the pain relief lasts. The clinical information submitted for review did not provide any evidence that a urine drug screen had been performed, no objective pain levels as scored on the Visual Analog Scale, and no functional measurements using a numerical scale or validated instrument. Furthermore, the multiple PR-2s from the treating pain physician, detail the patient's continuation of excruciating pain despite heavy opioid use, thereby indicating the inefficacy of the medication regimen. Furthermore, guidelines do not recommend morphine equivalency dosing in excess of 120 mg daily. According to the patient's current medication regimen, he utilizes up to 765 mg of morphine equivalents daily. As this is an excessive amount and is not providing the patient with sufficient pain control, as evidenced by his continued complaints of excruciating and unbearable pain, continued use of this medication is not indicated at this time. However, it is not recommended for abrupt discontinuation of opioids, and therefore, it is expected that the physician allow for safe weaning. As such, the request for OxyContin 80 mg #90 is non-certified.

OXYCODONE 30 MG #240: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS
Page(s): 74-95.

Decision rationale: California MTUS/ACOEM Practice Guidelines recommend opioids to treat moderate to severe chronic pain. In assessing the efficacy of opioid therapy, it is recommended that physicians obtain thorough pain assessments at each clinical visit, functional measurements at 6 month intervals using a numerical scale or validated instrument, and perform frequent random urine drug screens to monitor patient compliance. Pain assessments should include the patient's current pain levels, the least reported pain since the last assessment, average pain levels, and intensity of pain after taking the opioid, how long it takes for pain relief to begin, and how long the pain relief lasts. The clinical information submitted for review did not provide any

evidence that a urine drug screen had been performed, no objective pain levels as scored on Visual Analog Scale, and no functional measurements using a numerical scale or validated instrument. Furthermore, the multiple PR-2s from the treating pain physician detail the patient's continuation of excruciating pain despite heavy opioid use, thereby indicating the inefficacy of the medication regimen. Furthermore, guidelines do not recommend morphine equivalency dosing in excess of 120 mg daily. According to the patient's current medication regimen, he utilizes up to 765 mg of morphine equivalents daily. As this is an excessive amount and is not providing the patient with sufficient pain control, as evidenced by his continued complaints of excruciating and unbearable pain, continued use of this medication is not indicated at this time. However, it is not recommended for abrupt discontinuation of opioids, and therefore, it is expected that the physician allow for safe weaning. As such, the request for oxycodone 30 mg #240 is non-certified.

PERCOCET 10/325MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 74-95.

Decision rationale: California MTUS/ACOEM Practice Guidelines recommend opioids to treat moderate to severe chronic pain. In assessing the efficacy of opioid therapy, it is recommended that physicians obtain thorough pain assessments at each clinical visit, functional measurements at 6 month intervals using a numerical scale or validated instrument, and perform frequent random urine drug screens to monitor patient compliance. Pain assessments should include the patient's current pain levels, the least reported pain since the last assessment, average pain levels, intensity of pain after taking the opioid, how long it takes for pain relief to begin, and how long the pain relief lasts. The clinical information submitted for review did not provide any evidence that a urine drug screen had been performed, no objective pain levels as scored on the Visual Analog Scale, and no functional measurements using a numerical scale or validated instrument. Furthermore, the multiple PR-2s from the treating pain physician, detail the patient's continuation of excruciating pain despite heavy opioid use, thereby indicating the inefficacy of the medication regimen. Furthermore, guidelines do not recommend morphine equivalency dosing in excess of 120 mg daily. According to the patient's current medication regimen, he utilizes up to 765 mg of morphine equivalents daily. As this is an excessive amount and is not providing the patient with sufficient pain control, as evidenced by his continued complaints of excruciating and unbearable pain, continued use of this medication is not indicated at this time. However, it is not recommended for abrupt discontinuation of opioids and therefore, it is expected that the physician allow for safe weaning. As such, the request for Percocet 10/325 mg is non-certified.