

Case Number:	CM14-0044444		
Date Assigned:	07/02/2014	Date of Injury:	08/25/2004
Decision Date:	09/10/2014	UR Denial Date:	03/31/2014
Priority:	Standard	Application Received:	04/11/2014

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 North Carolina. 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 expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records: The patient is a 49-year-old with a reported date of injury of 08/25/2004. The patient has the diagnoses of bilateral sacroilitis; degenerative disc disease of the lumbosacral spine with probable facet mediated low back pain and herniated nucleus pulposus at T12, L1, L2-3, and L4-5 without radiculopathy. Past treatment, modalities have included facet injections, median branch block injections, epidural injections, and SI joint injections. Per the progress reports from the requesting physician dated 04/10/2014, the patient has complaints of continued pain with an overall improvement of 20%. Physical exam noted only that the patient was in no acute distress and that he stood and walked without pain. Treatment recommendations included continuation of current medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Duragesic 50mcg/hr QTY: 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 47.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-84.

Decision rationale: The Expert Reviewer's decision rationale: The California chronic pain medical treatment guidelines section on opioids states: 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, and 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 non-adherent) 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. (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. 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. The long-term use of opioids in chronic back pain is not recommended. There is a lack of documented significant quantitative and qualitative improvement on the medications. While the patient is under the care of pain management, the patient's daily morphine equivalent dose exceeds the 120mg per day that is recommended without documentation of significant improvement therefore this request is not medically necessary.

Percocet 10/325mg QTY: 900: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-84.

Decision rationale: The Expert Reviewer's decision rationale: The California chronic pain medical treatment guidelines section on opioids states: 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 non-adherent) 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. (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.

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. The long-term use of opioids in chronic back pain is not recommended. There is a lack of documented significant quantitative and qualitative improvement on the medications. While the patient is under the care of pain management, the patient's daily morphine equivalent dose exceeds the 120mg per day that is recommended without documentation of significant improvement therefore this request is not medically necessary.