

Case Number:	CM14-0195852		
Date Assigned:	12/03/2014	Date of Injury:	09/09/1994
Decision Date:	01/15/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	11/21/2014

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 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 injured is the 52-year-old female with a date of injury of September 9, 1994. She has chronic pain in the neck radiating into the right arm, pain in the shoulders, and the right knee. She has had 4 surgeries to the right shoulder, a lateral epicondyle release of the right elbow, a left sided carpal tunnel release surgery, an anterior fusion of C4, C5, and C6, and a total right knee replacement. The diagnoses include cervical spondylosis without myelopathy, fibromyalgia, chronic right shoulder pain, esophogitis, right knee pain, chronic vomiting, and depression. She has had vomiting for nearly 20 years, about the length of time that she has been on opioids. A recent upper endoscopy was essentially normal and the etiology of her vomiting is speculated to be gastroparesis. She has been on high-dose opioids for several years. She has been on morphine 100 mg 3 times daily and for the last year has been on Dilauded additionally, 4 mg 3 times daily. A review of over 500 documents shows no evidence of urine drug testing or inquiries into the pharmacy database. Pain scores are relatively rare in the record and are generally in the 8/10 range without mention of improvement quantitatively with the medication. Functionally, there are general references to injured worker being able to perform activities of daily living, however a note from July 30, 2014 indicates that she has aides to do her dishes, cook, take care of her animals, take care of her house, and wash her hair. There are no specific examples cited that indicate the injured worker actually is able to perform activities of daily living at home without assistance. At issue is a request for Kadian ER 100 mg quantity 90, Dilauded 4 milligrams quantity 120, and Promethazine 25mg quantity 60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Kadian ER 100mg quantity 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Urine drug testing, Opioids, tools for risk stratification & monitoring

Decision rationale: Those prescribed opioids chronically require ongoing assessment for pain relief, functionality, medication side effects, and any evidence of aberrant drug taking behavior. Opioids may generally be continued when there is evidence of pain relief and improvements in functionality as a consequence of the medication. Typical questions regarding pain include least amount of pain, average pain levels, worst pain, duration of analgesia for medication, and length of time for analgesia to occur with medication. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument. In this instance, the injured worker has been taking opioids at exceedingly high doses for several years. Over 500 documents were reviewed. The primary treating provider essentially documents nothing specifically regarding pain relief as a consequence of the medication except for very general statements. Additionally, the documentation provided by physicians other than the primary treating provider demonstrates that the injured worker is nearly entirely dependent on others for her activities of daily living. In essence, one cannot conclude that there is improved functionality as a consequence of the opioids for this injured worker. Additionally, a review of over 2 years of documentation does not lend support to the concept that there has been monitoring for aberrant drug taking behavior. There are no references to the CURES system and there are no urine drug screens for review. Patients at "moderate risk" for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. This includes patients undergoing prescribed opioid changes without success, patients with a stable addiction disorder, those patients in unstable and/or dysfunction social situations, and for those patients with comorbid psychiatric pathology. In this instance, the injured worker has been felt to have depression as an overlay to her pain syndrome. This would place her in the moderate risk for addiction/aberrant behavior category and hence urine drug testing 2 to 3 times yearly would be appropriate. In conclusion, objective evidence that the injured worker is achieving pain relief or has improved functionality as a consequence of her opioids is lacking. Appropriate urine drug screening is not occurring or least not documented for purposes of this review. Therefore, Kadian ER 100mg quantity 90 is not medically necessary per the references cited.

Dilaudid 4mg quantity 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydromorphone, Opioids, Criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Urine drug testing, Opioids, tools for risk stratification & monitoring

Decision rationale: Those prescribed opioids chronically require ongoing assessment for pain relief, functionality, medication side effects, and any evidence of aberrant drug taking behavior. Opioids may generally be continued when there is evidence of pain relief and improvements in functionality as a consequence of the medication. Typical questions regarding pain include least amount of pain, average pain levels, worst pain, duration of analgesia for medication, and length of time for analgesia to occur with medication. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument. In this instance, the injured worker has been taking opioids at exceedingly high doses for several years. Over 500 documents were reviewed. The primary treating provider essentially documents nothing specifically regarding pain relief as a consequence of the medication except for very general statements. Additionally, the documentation provided by physicians other than the primary treating provider demonstrates that the injured worker is nearly entirely dependent on others for her activities of daily living. In essence, one cannot conclude that there is improved functionality as a consequence of the opioids for this injured worker. Additionally, a review of over 2 years of documentation does not lend support to the concept that there has been monitoring for aberrant drug taking behavior. There are no references to the CURES system and there are no urine drug screens for review. Patients at "moderate risk" for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. This includes patients undergoing prescribed opioid changes without success, patients with a stable addiction disorder, those patients in unstable and/or dysfunction social situations, and for those patients with comorbid psychiatric pathology. In this instance, the injured worker has been felt to have depression as an overlay to her pain syndrome. This would place her in the moderate risk for addiction/aberrant behavior category and hence urine drug testing 2 to 3 times yearly would be appropriate. In conclusion, objective evidence that the injured worker is achieving pain relief (pain scores) or has improved functionality (functionality scales) as a consequence of her opioids is lacking. Appropriate urine drug screening is not occurring or least not documented for purposes of this review. Therefore, Dilaudid 4mg quantity 120 is not medically necessary per the references cited.

Promethazine 25mg quantity 60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Antiemetics, Pain (Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Antiemetics (for opioid nausea)

Decision rationale: Phenergan is not recommended for nausea and vomiting secondary to chronic opioid use. It is recommended as a sedative and antiemetic in pre-operative and post-operative situations. Multiple central nervous system effects are noted with use including

somnolence, confusion and sedation. Tardive dyskinesia is also associated with use. This is characterized by involuntary movements of the tongue, mouth, jaw, and/or face. Choreoathetoid movements of the extremities can also occur. Development appears to be associated with prolonged treatment and in some cases can be irreversible. In this instance, it appears that the injured worker had a remote history of a gastric ulcer but a recent endoscopy essentially showed no identifiable pathology. It has been speculated that she suffers from gastroparesis as a consequence of the opioids or possibly from irritable bowel syndrome. In either case, Phenergan is not recommended and is therefore not medically necessary per the referenced guidelines.