

Case Number:	CM14-0202266		
Date Assigned:	12/12/2014	Date of Injury:	04/04/2003
Decision Date:	01/30/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/03/2014

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 Practice, 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 injured worker is a 33 year-old male, who was injured on April 4, 2003, while performing regular work duties. The mechanism of injury is from getting the left thumb caught in a milk crate. The records indicate the injured worker has received treatment with injections, physical therapy, splinting, IV regional sympathetic blocks, Stellate Ganglion blocks, medications, interferential stimulation, medicinal marijuana, and multiple surgeries. The records indicate the injured worker has been using Oxycontin since at least June 28, 2012. The patient has the diagnosis of reflex sympathetic dystrophy. An agreed medical evaluation on June 11, 2014, indicates that on October 10, 2004, the injured worker went to the emergency room for pain, and refused to be admitted when this was recommended to do a regional pain block, and that currently the injured worker was unsure of what the injured worker "wants now". The agreed medical evaluator recommends spinal cord stimulation; however felt that the injured worker would not pass the psychological evaluation. An evaluation on August 6, 2014, indicates discussion with the injured worker regarding a Dorsal Column Stimulator and the injured worker wanting to wait on that treatment preferring medications. A letter from [REDACTED] on November 14, 2014, indicates the injured worker has a visual analogue scale pain of 10 without pain medications, which is down to 7 with pain medications. The request for authorization is for Oxycontin 10mg, quantity #120, and an evaluation for a functional restoration program. The primary diagnosis is autonomic nerve disorder. On November 21, 2014, Utilization Review provided a modified certification of Oxycontin 10mg, quantity #68; and non-certified the request for an evaluation for a functional restoration program, based on Chronic Pain Medical Treatment guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 10 mg #120: 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): 76-84.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: 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 non-opioid 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. When to Continue Opioids:(A) If the patient has returned to work.(B) If the patient has improved functioning and pain.(Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004)-Chronic back pain: Appears to be efficacious but limited for short-term pain relief, and long term efficacy is unclear (greater than 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. There is no evidence to recommend one opioid over another. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56% (a statistic limited by poor study design). Limited information indicated that up to

one-fourth of patients who receive opioids exhibit aberrant medication-taking behavior. (Martell-Annals, 2007) (Chou, 2007)The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. The most recent progress reports do not mention the patients work status. There is mention of improvement in VAS scores on medication (7/10) compared to without medications (10/10). There is no mention of objective functional improvement besides the non-specified or objective statement that pain medications help the patient to function in activities of daily living. For these reasons the criteria set forth above of ongoing and continued used of opioids have not been met. Therefore the request is not medically necessary.

1 Evaluation for functional restoration program: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs Page(s): 49.

Decision rationale: The California chronic pain medical treatment guidelines section on functional restoration programs states: Recommended, although research is still ongoing as to how to most appropriately screen for inclusion in these programs. Functional restoration programs (FRPs), a type of treatment included in the category of interdisciplinary pain programs (see Chronic pain programs), were originally developed by Mayer and Gatchel. FRPs were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. These programs emphasize the importance of function over the elimination of pain. FRPs incorporate components of exercise progression with disability management and psychosocial intervention. Long-term evidence suggests that the benefit of these programs diminishes over time, but still remains positive when compared to cohorts that did not receive an intensive program. (Bendix, 1998) A Cochrane review suggests that there is strong evidence that intensive multidisciplinary rehabilitation with functional restoration reduces pain and improves function of patients with low back pain. The evidence is contradictory when evaluating the programs in terms of vocational outcomes. (Guzman 2001) It must be noted that all studies used for the Cochrane review excluded individuals with extensive radiculopathy, and several of the studies excluded patients who were receiving a pension, limiting the generalizability of the above results. Studies published after the Cochrane review also indicate that intensive programs show greater effectiveness, in particular in terms of return to work, than less intensive treatment. (Airaksinen, 2006) There appears to be little scientific evidence for the effectiveness of multidisciplinary bio psychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. (Karjalainen, 2003) Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. While functional restoration programs are recommended with qualification per the California MTUS, they are not recommended for periods of greater than 2 weeks without evidence of objective gains. The request has no specified

time frame which is in excess of the recommendations. Therefore the request is not medically necessary.