

Case Number:	CM14-0202598		
Date Assigned:	12/15/2014	Date of Injury:	01/29/2013
Decision Date:	02/05/2015	UR Denial Date:	11/04/2014
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 Colorado. 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:

This is a 46-year-old female with a work related injury dated January 29, 2013. The injury was described as a lower back injury that occurred while the worker was lifting a patient out of a wheelchair. The worker then re-injured the back on January 17, 2014 when a patient fell on her. Treatment history has included chiropractic therapy, radio frequency ablation, pain medications and pain management physician's visits. Per the documentation of the physician's visit dated October 17, 2014 the worker was complaining of lower back pain radiating down the lower extremity to the knee and occasionally the foot. Exam was remarkable for range of motion of hip flexion at 70 degrees with forward reach to the mid-shin, extension of 20 degree and lateral bending of 30 degrees bilaterally. Straight leg raise tests were positive on the left and negative on the right. There was decreased sensation on the medial aspect of the left foot. Deep tendon reflexes were unattainable. A magnetic resonance imaging of the spine dated July 31, 2014 showed degenerative changes at the L4-5 and the L5-S1. Diagnoses included left sciatica and lumbar spondylosis with multiple annular tears and disc protrusions. The treatment plan at this visit included conservative care with continuation of pain medications, including Percocet. The utilization review decision dated November 4, 2014 non-certified the request for Percocet 10/325mg for a quantity of #90. An Independent Medical Review of that denial has been requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg QTY: 90.00: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments. Page(s): 79-80, 85, 88-89.

Decision rationale: The Guidelines establish criteria for use of opioids, including long term use (6 months or more). When managing patients using long term opioids, the following should be addressed: Re-assess the diagnosis and review previous treatments and whether or not they were helpful. When re-assessing, pain levels and improvement in function should be documented. (Information from sources other than patient can also be considered.) Pain levels should be documented every visit. Function should be evaluated every 6 months using a validated tool. Adverse effects, including hyperalgesia, should also be addressed each visit. Patient's motivation and attitudes about pain / work / interpersonal relationships can be examined to determine if patient requires psychological evaluation as well. Aberrant / addictive behavior should be addressed if present. Do not decrease dose if effective. Medication for breakthrough pain may be helpful in limiting overall medication. Follow up evaluations are recommended every 1-6 months. To summarize the above, the 4A's of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors) have been established. 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) Several circumstances need to be considered when determining to discontinue opioids: 1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of opioids 2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to opioids, and aggressive or threatening behavior in clinic. Weaning from the medication over 30 day period, under direct medical supervision, is recommended unless a reason for immediate discontinuation exists. If a medication contract is in place, some physicians will allow one infraction without immediate discontinuation, but the contract and clinic policy should be reviewed with patient and consequences of further violations made clear to patient. 3) Consider discontinuation if there has been no improvement in overall function, or a decrease in function. 4) Patient has evidence of unacceptable side effects. 5) Patient's pain has resolved. 6) Patient exhibits "serious non-adherence / misuse" (including urine drug testing negative for prescribed substances on 2 occasions) Per the Guidelines, Chelminski defines "serious substance misuse" as meeting any of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for opioids not routinely prescribed. (Chelminski, 2005) 7) Patient requests discontinuing opioids. 8) Consider verifying that patient is in consultation with physician specializing in addiction to consider detoxification if patient continues to violate the medication contract or shows other signs of abuse / addiction. 9) Document the basis for decision to discontinue opioids. Likewise, when making the decision to continue opioids long term, consider the following: Has patient returned to work? Has patient had improved function and decreased pain with the opioids? For the patient of concern, the most

recent office visit with the treating physician, a pain management physician, 12/4/2014, satisfies the documentation requirements specified in the Guidelines. Patient's pain is improved with Percocet as part of her regimen (from 8/10 to 4/10 with medications), and functional improvement is objectively improved as well, and records indicates patient is CURES appropriate. The treating physician has documented the 4A"S of monitoring and indicated urine drug screens are consistent. Per the records, patient is taking Percocet only as prescribed, 3 tablets per day, and following treatment plan. The patient is also continuing to work, so the regimen is maintaining her. The Percocet is deemed medically necessary.