

<b>Case Number:</b>	CM14-0208640		
<b>Date Assigned:</b>	12/22/2014	<b>Date of Injury:</b>	06/06/2006
<b>Decision Date:</b>	02/20/2015	<b>UR Denial Date:</b>	12/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/12/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Colorado  
 Certification(s)/Specialty: Family Practice

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

55 year old female with date of injury 6/6/2006 continues care with the treating physician. Patient has diagnoses including lumbar radiculopathy, post-laminectomy syndrome, and spinal stenosis and she has chronic low back pain currently managed with Morphine, Oxycodone, Cymbalta, and Xanax. Patient has had multi-level lumbar fusion in 2008 without any relief of her pain. Sacroiliac joint injection in 2014 did provide 70% relief of Right sacroiliac joint pain, per the records. Treating physician examination in December reveals pain in all range of motion for lower extremities and low back, positive pelvic rock and bilateral sustained hip flexion, and positive sacroiliac provocative maneuvers on the right. Patient's pain at this visit reported to be 50% less with Oxycodone, and Oswestry Disability Index noted to be improved with Oxycodone as well (33 on Oxycodone versus 42 off Oxycodone)The treating physician requests ongoing approval for Oxycodone and retroactive approval for Urine Drug Screen performed 11/11/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone 10MG #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
 Page(s): 78, 86.

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

**Decision rationale:** The MTUS 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 records do indicate that patient has had improvement in pain (50%) though no pain ratings are in the records to correlate with that. Also, the records indicate an objective assessment of functional improvement (Oswestry Disability Index) that confirms improvement in function as well.

However, 2 separate urine drug screens on patient were positive for Hydrocodone, a medication not prescribed for the patient by the treating physician. Only one of these inconsistent urine drug screens is addressed in the record, and patient indicated she took an "old" prescription she "found" at home, which is a violation of pain contract noted to be in effect in the record. Per the Guidelines, urine toxicology screen positive on at least two occasions for opioids not routinely prescribed is considered serious misuse / non-adherence to opioid use and warrants immediate discontinuation of opioids. As patient has already exhibited serious misuse of opioids, further opioid prescriptions, including Oxycodone, are not medically indicated per guidelines. Therefore, the request is not medically necessary.

**Urine Drug Screen on 11/11/14:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 49. Decision based on Non-MTUS Citation Official Disability Guidelines-Pain, Urine drug testing

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 78-79, and 85.

**Decision rationale:** Per the Guidelines, opioid use should be monitored, and there are tools recommended for that, including the 4 A's for Ongoing Monitoring: Analgesia, Adverse effects, Activities of Daily Living, and Aberrant behaviors. Urine drug screens positive for substances not prescribed would be indicators of possible aberrant behavior including noncompliance and diversion. Within the Guidelines, Chelminski includes urine toxicology screen positive on at least two occasions for opioids not routinely prescribed as one of the criteria defining serious substance misuse / non-adherence. Furthermore, evidence of serious non-adherence warrants immediate discontinuation of opioids. As of 7/16/2014 urine drug screen in the records, patient was positive for Hydrocodone, a medication not prescribed for her by the treating physician. This finding occurred again on urine drug screen 10/14/2014, and patient indicated she had recently "found" on old prescription of Vicodin and taken it. Given evidence of 2 urine drug screens, several months apart, positive for an opioid not prescribed for patient, in addition to her prescribed opioids, the patient is clearly exhibiting aberrant drug taking behavior that could cause adverse events, so opioids would no longer be indicated for this patient. As patient has already exhibited serious misuse of opioids and opioids are to be discontinued, no further urine drug testing is medically necessary. Therefore, the request is not medically necessary.