

Case Number:	CM14-0062784		
Date Assigned:	07/11/2014	Date of Injury:	03/13/2007
Decision Date:	04/06/2015	UR Denial Date:	05/02/2014
Priority:	Standard	Application Received:	05/05/2014

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: Arizona, California

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:

The injured worker is a 58 year old male, who sustained an industrial injury on 3/13/07. He has reported back injury. The diagnoses have included post laminectomy syndrome, chronic pain syndrome and narcotic dependency. Treatment to date has included laminectomy and opioid medications. Currently, the injured worker complains of low back pain. On 5/6/14, physical exam noted he ambulated with a seated walker and appears anxious. It is noted the injured worker was without his medications for 4 days and complained of dizziness, sweating, vomiting and irritability. On 5/2/14 Utilization Review non-certified OxyContin 20mg # 120, noting addition of another opioid based medication is not supported and submitted modified certification for Oxycodone 10mg #80 modified to #68, noting the guidelines do not support long term use without documentation of functional improvement, modification is allowed for weaning. The MTUS, ACOEM Guidelines, was cited. On 5/5/14, the injured worker submitted an application for IMR for review of Oxycodone 10mg #80 modified to #68 and OxyContin 20mg # 120.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 10 mg #80: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids, weaning opioids Page(s): 82-92, 124.

Decision rationale: Oxycodone is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Oxycodone for years without significant improvement in pain (8/10). The physician mentioned weaning opioids. The guidelines for weaning note: For opioids a slow taper is recommended. The longer the patient has taken opioids, the more difficult they are to taper. The process is more complicated with medical comorbidity, older age, female gender, and the use of multiple agents. Gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms. (Benzon, 2005) Patients with complex conditions with multiple comorbidities (including psych disorders) should be referred to an addiction medicine/psychiatry specialist. Opioid weaning should include the following: (a) Start with a complete evaluation of treatment, comorbidity, psychological condition; (b) Clear written instructions should be given to the patient and family; (c) If the patient cannot tolerate the taper, refer to an expert (pain specialist, substance abuse specialist); (d) Taper by 20 to 50% per week of original dose for patients who are not addicted (the patient needs 20% of the previous day's dose to prevent withdrawal); (e) A slower suggested taper is 10% every 2 to 4 weeks, slowing to a reductions of 5% once a dose of 1/3 of the initial dose is reached; (f) Greater success may occur when the patient is switched to longer-acting opioids and then tapered; (g) Office visits should occur on a weekly basis; (h) Assess for withdrawal using a scale such as the Subjective Opioid Withdrawal Scale (SOWS) and Objective Opioid Withdrawal Scale (OOWS). In this case, a weaning protocol following a treatment plan as above was not provided. The Oxycodone as prescribed above is not substantiated or supported by the clinical protocol and not medically necessary.

Oxycontin 20 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, weaning opioids Page(s): 82-92, 124.

Decision rationale: According to the MTUS guidelines, Oxycontin is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Oxycontin for several years without significant improvement in pain (8/10). The physician mentioned weaning opioids. The guidelines for weaning note: For opioids a slow taper is recommended. The longer the patient has taken opioids, the more difficult they are to taper. The process is more

complicated with medical comorbidity, older age, female gender, and the use of multiple agents. Gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms. (Benzon, 2005) Patients with complex conditions with multiple comorbidities (including psych disorders) should be referred to an addiction medicine/psychiatry specialist. Opioid weaning should include the following: (a) Start with a complete evaluation of treatment, comorbidity, psychological condition; (b) Clear written instructions should be given to the patient and family; (c) If the patient cannot tolerate the taper, refer to an expert (pain specialist, substance abuse specialist); (d) Taper by 20 to 50% per week of original dose for patients who are not addicted (the patient needs 20% of the previous day's dose to prevent withdrawal); (e) A slower suggested taper is 10% every 2 to 4 weeks, slowing to a reductions of 5% once a dose of 1/3 of the initial dose is reached; (f) Greater success may occur when the patient is switched to longer-acting opioids and then tapered; (g) Office visits should occur on a weekly basis; (h) Assess for withdrawal using a scale such as the Subjective Opioid Withdrawal Scale (SOWS) and Objective Opioid Withdrawal Scale (OOWS). In this case, a weaning protocol following a treatment plan as above was not provided. The Oxycontin as prescribed above is not substantiated or supported by the clinical protocol and not medically necessary.