

Case Number:	CM15-0101620		
Date Assigned:	06/04/2015	Date of Injury:	04/16/2013
Decision Date:	07/03/2015	UR Denial Date:	05/16/2015
Priority:	Standard	Application Received:	05/27/2015

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: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 59-year-old male patient who sustained an industrial injury on 04/16/2013. The accident was described as having had slipped and fallen with resulting injury. Of note, the patient has a history of chronic lumbar back pain and reportedly known bulging disc disorder. He presented to the ER with a subjective complaint of lumbar pain rated a 10 in intensity that radiates down the lateral aspect of his thigh. He was seen in the emergency room, assessed and received Dilaudid, Valium, and Toradol with good relief of discomfort. He was discharged to home, given prescriptions for Norco, Valium, and Naprosyn along with back injury instructions, and urged to follow up with primary treating doctor. The assessment found the patient with: status post slip and fall with acute on chronic lumbar back pain; degenerative changes of L5, S1 and posterior disc protrusion at L3-4 with no evidence of acute spinal cord or spinal nerve impingement syndrome. On 03/10/2015, he underwent a magnetic resonance imaging (MRI) study of lumbar spine, which revealed the L5-S1 disc is severely degenerated. The right lateral disc protrusions cause neural foraminal stenosis, mild at L1-2 and moderate at L2-3. There is left paracentral disc protrusion at L3-4 contacts and dorsally displaces the traversing left L4 nerve roots and moderately narrows the left neural foramen. The exiting nerve L5 nerve roots are contacted in the L5-S1 neural foramina bilaterally. The L4-5 disc disorder is associated with an annular fissure. There is facet joint arthropathy mild bilaterally at L3-4, L4-5 and L5-S1. Treatment to date has included physical therapy and medications. A PR-2 dated 02/19/2015 reported the patient continued complaints of chronic back pain in the lumbar spine worse with walking, standing or sitting and radiating into the left lower extremity. On exam,

there were increased spasms in the L2-5 area, decreased lordosis and crepitus was present. His medications included; Gabapentin and Oxycodone. His tramadol was stopped.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 30 MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-9, Chronic Pain Treatment Guidelines Medications for chronic pain; Opioids; Weaning of medications Page(s): 60-1, 74-96, 124.

Decision rationale: Oxycodone (Oxycontin) is a semi synthetic opioid indicated for treatment of moderate to severe pain available in immediate release (Oxycodone IR) and controlled release forms. According to the MTUS, opioid therapy for control of chronic pain, while not considered first line therapy, is considered a viable alternative when other modalities have been tried and failed. When being used to treat neuropathic pain it is considered a second-line treatment (first-line medications are antidepressants and anticonvulsants), however, there are no long-term studies to suggest chronic use of opioids for neuropathic pain. It is known that long-term use of opioids is associated with hyperalgesia and tolerance. Success of this therapy is noted when there is significant improvement in pain or function. It is important to note, however, the maximum daily dose of opioids, calculated as morphine equivalent dosing from use of all opioid medications, is 120 mg per day. The major risks of opioid therapy are the development of addiction, overdose and death. The pain guidelines in the MTUS directly address opioid use by presenting a number of recommendations required for providers to document safe use of these medications. The patient has been using opioid medications for over 6 months. The patient's present dose has a total morphine equivalent dose of 135 mg per day. There is no documentation of a drug contract with the patient for single provider prescribing opioid medications. Additionally, there was no evidence in the records available for review of prior or recent urine drug testing to screen for opioid abuse but the provider does note there was no drug seeking behaviors noted. The opioid medication does appear to lessen the pain and improve function but without following all the MTUS criteria for long-term opioid use, patient safety is at risk. Given all the above information, at this time in the care of this patient further use of opioid medications is still recommended but the dose should be lowered to the MTUS recommended maximum dose of 120 mg unless the patient is followed by a pain specialist and better documentation using the MTUS guidelines is suggested. Medical necessity for continued use of this medication at the dose of 30mg three times per day has not been established.