

<b>Case Number:</b>	CM15-0135141		
<b>Date Assigned:</b>	07/23/2015	<b>Date of Injury:</b>	01/19/2000
<b>Decision Date:</b>	08/25/2015	<b>UR Denial Date:</b>	07/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/13/2015

### 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: Georgia

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 61-year-old female, who sustained an industrial injury on 1/19/00. Initial complaint was of a low back injury. The injured worker was diagnosed as having lumbar disc degeneration; lumbago; postlaminectomy syndrome-lumbar. Treatment to date has included status post lumbar discectomy fusion L5-S1 (1992); status post lumbar decompression/fusion L4-5/internal fixation (2/9/03); status post permanent placement of Morphine Intrathecal pump (3/2/05); chiropractic therapy; physical therapy; aquatic therapy; TENS unit; Toradol injections; psychotherapy; mattress; cane; intrathecal pump; urine drug screening; medications. Diagnostics studies included MRI lumbar spine (4/26/01). Currently, the PR-2 notes dated 4/29/15 indicated the injured worker is in the office on this date for an intrathecal pump refill. There are no changes in her health status and she is having more muscle spasms and has completely stopped the Soma on the provider's direction. She is reporting more leg cramps and spasming nearly on a daily basis; however, she has not started using the Orphenadrine given as a substitute because she was unsure what the medication was to be used for. The provider documents, otherwise she is using the same amount of Norco and oxycodone. She requires a refill of both and notes Norco is filled by private provider and oxycodone is per her industrial claim. Her clinical history is documented as migraine headaches, hypertension and kidney disease. She has had a nephrectomy, knee surgery with an osteomyelitis of the right leg and an L5-S1 lumbar surgery and then fusion times two. Her pain pump was interrogated and no difficulty accessing and refilling on this date. The provider is requesting authorization of retrospective Morphine pump refill for date of service 4/29/15 and oxycontin 40mg #120 for date of service 4/29/15.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Retrospective Oxycontin 40mg #120 for DOS 4/29/2015: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79.

**Decision rationale:** Retrospective Oxycontin 40mg #120 for DOS 4/29/2015 is not medically necessary. The patient already has a functioning morphine pump and her dose of opioids exceeds 120 mg of Morphine equivalent with oral opioids alone. Her current dose of opioids is not indicated for non-malignant pain. **CRITERIA FOR USE OF OPIOIDS:** 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 nonadherent) 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 nonopioid 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. 6) When to Discontinue Opioids: See Opioid hyperalgesia. Also, see Weaning of Medications. Prior to discontinuing, it should be determined that the patient has not had treatment failure due to causes that can be corrected such as under-dosing or inappropriate dosing schedule. Weaning should occur under direct ongoing

medical supervision as a slow taper except for the below mentioned possible indications for immediate discontinuation. The patient should not be abandoned. (a) If there is no overall improvement in function, unless there are extenuating circumstances. (b) Continuing pain with the evidence of intolerable adverse effects. (c) Decrease in functioning. (d) Resolution of pain. (e) If serious non-adherence is occurring. (f) The patient requests discontinuing. (g) Immediate discontinuation has been suggested for: evidence of illegal activity including diversion, prescription forgery, or stealing; the patient is involved in a motor vehicle accident and/or arrest related to opioids, illicit drugs and/or alcohol; intentional suicide attempt; aggressive or threatening behavior in the clinic. It is suggested that a patient be given a 30-day supply of medications (to facilitate finding other treatment) or be started on a slow weaning schedule if a decision is made by the physician to terminate prescribing of opioids/controlled substances. (h) Many physicians will allow one "slip" from a medication contract without immediate termination of opioids/controlled substances, with the consequences being a re-discussion of the clinic policy on controlled substances, including the consequences of repeat violations. (i) If there are repeated violations from the medication contract or any other evidence of abuse, addiction, or possible diversion it has been suggested that a patient show evidence of a consult with a physician that is trained in addiction to assess the ongoing situation and recommend possible detoxification. (Weaver, 2002) (j) When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, physicians and surgeons who make a clinical decision to withhold opioid medications should document the basis for their decision. 7) When to Continue Opioids (a) If the patient has returned to work, (b) If the patient has improved functioning and pain Opioids, dosing Recommend that dosing not exceed 120 mg oral morphine equivalents per day, and for patients taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose.