

Case Number:	CM15-0140092		
Date Assigned:	07/30/2015	Date of Injury:	06/12/2000
Decision Date:	09/24/2015	UR Denial Date:	07/08/2015
Priority:	Standard	Application Received:	07/20/2015

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 56 year old male who sustained an industrial injury on 06-12-2000 resulting in injury to the cervical spine after falling backwards and striking his neck. Loss of consciousness was reported. The injured worker's work status was noted as permanent and stationary. Treatment provided to date has included: cervical spine posterior foraminotomy surgeries (times 4); physical therapy; cervical epidural steroid injections; and medications. Diagnostic tests performed include: MRI of the cervical spine (2015) showing anterior fusion change at C3-6 with significant metallic artifact arising from the C3-4 level, an osteophytic ridge centrally measuring 2-3mm resulting in mild dural compression, and a probable cyst in the posterior neck measuring 7mm at the T1-2 level. Comorbidities included hypertension. In a psychiatric note dated 06-03-2015 the injured worker reported going to Mexico every other month to see a doctor there who prescribes Norco. This note also gave the patient an Axis I diagnosis of opioid dependence, claimed in sustained remission. On 06-24-2015, physician progress report noted complaints of constant neck pain. The pain was rated 10 out of 10 in severity at its worst and 7 out of 10 during this visit. The pain was described as aching and frequent, and reported to be aggravated with waking up in the mornings and alleviated with medication and cold packs. Activities of daily living (ADLs) were reported to be painful and difficult but pain medications allow him to function. Current non-industrial injury medications include blood pressure medication and high cholesterol medication. The injured worker noted that in the past the once per day dose of oxycodone helped the most. The physical exam revealed tenderness to palpation of the cervical paraspinals, restricted range of motion (ROM) in the

cervical spine, restricted upper extremity ROM, normal strength, sensation and reflexes. The provider noted diagnoses of status post total disc arthroplasty at C3-4, anterior cervical discectomy and fusion at C5-6, C3-4 and C4-5 cervical stenosis, bilateral cervical radiculopathy, cervical adjacent segment degeneration at C3-4 and C5-6 above and below the C4-5 fusion, and status post C4-5 fusion. Plan of care includes Oxycodone 10mg one at hour of sleep, Celebrex for inflammation, Lyrica for nerve pain, Omeprazole for gastritis caused by Celebrex, signed opioid agreement on 06-24-2015, and follow-up in 4 weeks. It was reported that the injured worker is taking minimal doses of his medications, and has shown no signs of abuse or misuse. On 07-17-2015 the injured worker was seen by a different orthopedist office and prescribed

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone HCL 10mg #30: 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 Page(s): 60-1, 74-96.

Decision rationale: Oxycodone (OxyContin) is a semisynthetic opioid indicated for treatment of moderate to severe pain available in immediate release (Oxycodone IR) and controlled release (OxyContin ER) 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. For this patient the safe use of chronic opioid medications is in question. Even though the patient signed a single source opioid contract it appears the patient is getting opioids from three different providers, since the patient has a past history and diagnosis of opioid dependence this finding is very concerning. The morphine equivalent dose (MED) of his opioid medications is hard to calculate since the notes do not include the Mexican doctor's progress notes but if the patient is truthfully taking Norco twice per day and Oxycodone only once per day the MED is well below the upper limit of safety. Until this information is resolved and the patient understands the concept of only one provider prescribing opioids, adding Oxycodone to the patient's therapy is not indicated. Medical necessity has not been established.