

Case Number:	CM15-0142855		
Date Assigned:	08/04/2015	Date of Injury:	09/02/2011
Decision Date:	09/18/2015	UR Denial Date:	07/07/2015
Priority:	Standard	Application Received:	07/23/2015

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: New York

Certification(s)/Specialty: Internal 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 49 year old female, who sustained an industrial injury on 9-2-2011. The mechanism of injury was not described. The current diagnoses are cervical radiculopathy, muscle spasms, thoracic pain, and lumbar-sacral radiculopathy, degenerative disc disease of the lumbar spine, status post lumbar surgery, and left shoulder pain. According to the progress report dated 7-8-2015, the injured worker complains of persistent neck pain. She also reports muscle spasms in her neck that are worse at night. The level of pain was not rated. The physical examination of the cervical spine reveals moderate tenderness over the paraspinal muscles, significant muscle spasms, decreased range of motion, diffuse upper extremity weakness, and diminished sensation in the left 5th finger. The current medications are OxyContin, Oxycodone, Xanax, Adderall, Prozac, and Wellbutrin XL. She notes that her current regimen is providing modest relief and allowing improved activity levels on most days. There is documentation of ongoing treatment with OxyContin and Oxycodone since at least 12-22-2014. Flexeril was initiated on 12-22-2014. It is unclear when Percocet, Dilaudid, Phenergan, Cymbalta, Norco, and Baclofen were originally prescribed. Per the progress note on 12-22-2014, Dilaudid was discontinued. According to the progress report on 2-17-2015, Dilaudid was re-initiated at a lower dose for post-operative pain. There is no documentation regarding the lumbar epidural steroid injection. Treatment to date has included medication management, x-rays, MRI studies, TENS unit, home exercises, and surgical intervention. She has not started physical therapy, secondary to family stressors. MRI of the cervical spine from 6-2011 showed reversal of normal cervical lordosis, mild-to-moderate narrowing at C4-5 with mild spondylosis, minimal disc bulge at C3-4, C4-5, and C7-T1, and C6-7 disc osteophyte with mild neural foraminal stenosis. The

most recent MRI of the cervical spine from 6-2014 shows mild-to-moderate multilevel degenerative disc disease. There is a 4 millimeter left disc osteophyte complex at the C6-7. There is mild narrowing of the left neural foramen. MRI of the lumbar spine from 6-2011 showed mild disc bulge L4-5 new since previous study, L5-S1 mild disc bulge with small annular tear. Her most recent MRI of the lumbar spine from 3-2014 reveals status post anterior lumbar interbody fusion and posterior lumbar interbody fusion between L4 and S1 without evidence of hardware failure or neural impingement. Work status is described as temporarily totally disabled. A request for Flexeril, Phenergan, OxyContin, Oxycodone, cervical MRI, lumbar MRI, Cymbalta, Percocet, Norco, Baclofen, Dilaudid, and lumbar epidural steroid injection has been submitted

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Flexeril 10mg #45 DOS: 9/12/11: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63 and 64.

Decision rationale: Per CA MTUS Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine (Flexeril) is a skeletal muscle relaxant and a central nervous system (CNS) depressant. Guidelines recommend Cyclobenzaprine (Flexeril) be used as an option, using a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief. Furthermore, muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. The addition of cyclobenzaprine to other agents is not recommended. In this case, the guidelines specifically note that muscle relaxants do not prove to be any more effective than NSAIDs alone for the treatment of low back pain. Although the current medications are subjectively reported to provide modest relief and allow for an improved activity level, there is no supporting evidence of objective functional improvement such as measurable decrease in frequency and intensity of spasms. Also, the guidelines do not support the addition of Cyclobenzaprine to any other agents. Therefore, based on CA MTUS guidelines and submitted medical records, the request for retrospective Flexeril is not medically necessary.

Retrospective request for Phenergan 25mg #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic): Promethazine (Phenergan) and Antiemetics (for opioid nausea), 2015.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter: Antiemetics.

Decision rationale: The CA MTUS is silent regarding the use of Promethazine. However, per the Official Disability Guidelines, Promethazine (Phenergan) is not recommended for nausea and vomiting secondary to chronic opioid use. It is recommended as a sedative and antiemetic in pre-operative and post-operative situations. Multiple central nervous system effects are noted with use including somnolence, confusion and sedation. Tardive dyskinesia is also associated with use. This is characterized by involuntary movements of the tongue, mouth, jaw, and/or face. Choreoathetoid movements of the extremities can also occur. Development appears to be associated with prolonged treatment and in some cases can be irreversible. In this case, the Official Disability Guidelines does not support Promethazine (Phenergan) for nausea and vomiting secondary to chronic opioid use. Promethazine is recommended in perioperative situations. The submitted medical records failed to provide documentation regarding perioperative care that would support the use of Promethazine. Therefore, based on Official Disability Guidelines and submitted medical records, the request for retrospective Phenergan is not medically necessary.

Retrospective request for Oxycontin 60mg #90 DOS: 9/12/11: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone controlled release (Oxycontin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines discourages long term usage unless there is evidence of "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 non-adherent) 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. Additionally, the recommended opioid dosing should 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. In general, the total daily dose of opioid should not exceed 120 mg oral morphine equivalents. In this case, the treating physician did not

document the least reported pain over the period since last assessment, average pain, and intensity of pain after taking the opioid, how long it takes for pain relief, how long pain relief lasts, improvement in pain, and improvement in function. These are necessary to meet the CA MTUS guidelines. Although the current medications are subjectively reported to provide modest relief of pain, and allow for an improved activity level, there is no supporting evidence of objective functional improvement such as measurable decrease in frequency and intensity of pain per the VAS scale. The work status is described as "temporarily totally disabled", which implies a complete lack of functional improvement. In addition, opioid dosing should not exceed 120 mg oral morphine equivalents per day. When all opioid medications are factored in, the injured workers daily morphine equivalent dose is substantially higher than the CA MTUS recommended dose of 120 mg per 24 hours. Therefore, based on CA MTUS guidelines and submitted medical records, the request for retrospective OxyContin is not medically necessary.

Retrospective request for Oxycodone 20mg # 150 DOS: 9/12/11: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines discourages long term usage unless there is evidence of "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 non-adherent) 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. Additionally, the recommended opioid dosing should 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. In general, the total daily dose of opioid should not exceed 120 mg oral morphine equivalents. In this case, the treating physician did not document the least reported pain over the period since last assessment, average pain, and intensity of pain after taking the opioid, how long it takes for pain relief, how long pain relief lasts, improvement in pain, and improvement in function. These are necessary to meet the CA MTUS guidelines. Although the current medications are subjectively reported to provide modest relief of pain, and allow for an improved activity level, there is no supporting evidence of objective functional improvement such as measurable decrease in frequency and intensity of pain

per the VAS scale. The work status is described as “temporarily totally disabled”, which implies a complete lack of functional improvement. In addition, opioid dosing should not exceed 120 mg oral morphine equivalents per day. When all opioid medications are factored in, the injured workers daily morphine equivalent dose is substantially higher than the CA MTUS recommended dose of 120 mg per 24 hours. Therefore, based on CA MTUS guidelines and submitted medical records, the request for retrospective Oxycodone is not medically necessary.

Retrospective request for 1 cervical MRI DOS: 6/21/11: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178 and 182.

Decision rationale: According to the CA ACOEM Medical Treatment Guidelines, special diagnostic studies are for patients presenting with true neck or upper back problems. Special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. Criteria for ordering imaging studies are: emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. In this case, the submitted medical records failed to provide adequate clinical findings and/or presence of red flags to support diagnostic imaging of the cervical spine. Therefore, based on ACOEM guidelines and submitted medical records, the request for retrospective MRI of the cervical spine is not medically necessary.

Retrospective request for 1 lumbar MRI DOS: 6/21/11: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back & Lumbar & Thoracic (Acute & Chronic): MRIs (magnetic resonance imaging), 2015.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303 and 304.

Decision rationale: Per the CA ACOEM Medical Treatment Guidelines relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. In this case, the submitted medical records failed to provide adequate clinical findings and/or presence of red flags to support diagnostic imaging of the lumbar spine. Therefore, based on ACOEM guidelines

and submitted medical records, the request for retrospective MRI of the lumbar spine is not medically necessary.

Retrospective request for Cymbalta 30mg #30 DOS: 6/21/11: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16.

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines, Cymbalta (Duloxetine) is an antidepressant in the class called Selective serotonin and norepinephrine reuptake inhibitors (SNRIs). The guidelines recommend Cymbalta be used as an option in first-line treatment of diabetic neuropathy. More studies are needed to determine the efficacy of Duloxetine for other types of neuropathic pain. It has FDA approval for treatment of depression, generalized anxiety disorder, diabetic neuropathy, and fibromyalgia. No high quality evidence is reported to support the use of Duloxetine for lumbar radiculopathy. In this case, the submitted medical records failed to provide documentation regarding signs and symptoms and-or a diagnosis of depression, anxiety, diabetic neuropathy, or fibromyalgia that would support the use of Duloxetine. Therefore, based on CA MTUS guidelines and submitted medical records, the request for retrospective Cymbalta is not medically necessary.

Retrospective request for Percocet 10/325mg #60 DOS: 6/21/11: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone/Acetaminophen (Percocet) and Opioids, dosing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines discourages long term usage unless there is evidence of "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 non-adherent) 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. Additionally, the recommended

opioid dosing should 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. In general, the total daily dose of opioid should not exceed 120 mg oral morphine equivalents. In this case, the treating physician did not document the least reported pain over the period since last assessment, average pain, and intensity of pain after taking the opioid, how long it takes for pain relief, how long pain relief lasts, improvement in pain, and improvement in function. These are necessary to meet the CA MTUS guidelines. Although the current medications are subjectively reported to provide modest relief of pain, and allow for an improved activity level, there is no supporting evidence of objective functional improvement such as measurable decrease in frequency and intensity of pain per the VAS scale. The work status is described as "temporarily totally disabled", which implies a complete lack of functional improvement. In addition, opioid dosing should not exceed 120 mg oral morphine equivalents per day. When all opioid medications are factored in, the injured workers daily morphine equivalent dose is nearly five times higher than the CA MTUS recommended dose of 120 mg per 24 hours. Therefore, based on CA MTUS guidelines and submitted medical records, the request for retrospective Percocet is not medically necessary.

Retrospective request for Oxycontin 60mg #90 DOS: 6/21/11: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone controlled release (Oxycontin) and Opioids, dosing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines discourages long term usage unless there is evidence of "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 non-adherent) 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. Additionally, the recommended opioid dosing should 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. In general, the total daily dose of opioid should not exceed 120 mg oral morphine equivalents. In this case, the treating physician did not document the least reported pain over the period since last assessment, average pain, and intensity of pain after taking the opioid, how long it takes for pain relief, how long pain relief

lasts, improvement in pain, and improvement in function. These are necessary to meet the CA MTUS guidelines. Although the current medications are subjectively reported to provide modest relief of pain, and allow for an improved activity level, there is no supporting evidence of objective functional improvement such as measurable decrease in frequency and intensity of pain per the VAS scale. The work status is described as "temporarily totally disabled", which implies a complete lack of functional improvement. In addition, opioid dosing should not exceed 120 mg oral morphine equivalents per day. When all opioid medications are factored in, the injured workers daily morphine equivalent dose is substantially higher than the CA MTUS recommended dose of 120 mg per 24 hours. Therefore, based on CA MTUS guidelines and submitted medical records, the request for retrospective OxyContin is not medically necessary.

Retrospective request for 1 lumbar epidural steroid injection DOS: 9/12/11: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: According to the CA MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) See also Epidural steroid injections, "series of three." In this case, the submitted medical records do not reflect any current objective evidence of radiculopathy to support the use of epidural steroid injections. In addition, there is no evidence that recent conservative therapy other than medication had been attempted. Therefore, based on CA MTUS guidelines and submitted medical records, the request for retrospective lumbar epidural steroid injection is not medically necessary.

Retrospective request for Norco 10/325mg #60 DOS: 12/27/11: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen (Norco).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 74-96.

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines discourages long term usage unless there is evidence of "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 non-adherent) 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. Additionally, the recommended opioid dosing should 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. In general, the total daily dose of opioid should not exceed 120 mg oral morphine equivalents. In this case, the treating physician did not document the least reported pain over the period since last assessment, average pain, and intensity of pain after taking the opioid, how long it takes for pain relief, how long pain relief lasts, improvement in pain, and improvement in function. These are necessary to meet the CA MTUS guidelines. Although the current medications are subjectively reported to provide modest relief of pain, and allow for an improved activity level, there is no supporting evidence of objective functional improvement such as measurable decrease in frequency and intensity of pain per the VAS scale. The work status is described as "temporarily totally disabled", which implies a complete lack of functional improvement. In addition, opioid dosing should not exceed 120 mg oral morphine equivalents per day. When all opioid medications are factored in, the injured workers daily morphine equivalent dose is nearly five times higher than the CA MTUS recommended dose of 120 mg per 24 hours. Therefore, based on CA MTUS guidelines and submitted medical records, the request for retrospective Norco is not medically necessary.

Retrospective request for Oxycontin 60mg #120 DOS: 12/7/11: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone controlled release (Oxycontin) and Opioids, dosing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 74-96.

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines discourages long term usage unless there is evidence of "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 non-adherent) 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. Additionally, the recommended opioid dosing should 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. In general, the total daily dose of opioid should not exceed 120 mg oral morphine equivalents. In this case, the treating physician did not document the least reported pain over the period since last assessment, average pain, and intensity of pain after taking the opioid, how long it takes for pain relief, how long pain relief lasts, improvement in pain, and improvement in function. These are necessary to meet the CA MTUS guidelines. Although the current medications are subjectively reported to provide modest relief of pain, and allow for an improved activity level, there is no supporting evidence of objective functional improvement such as measurable decrease in frequency and intensity of pain per the VAS scale. The work status is described as "temporarily totally disabled", which implies a complete lack of functional improvement. In addition, opioid dosing should not exceed 120 mg oral morphine equivalents per day. When all opioid medications are factored in, the injured workers daily morphine equivalent dose is substantially higher than the CA MTUS recommended dose of 120 mg per 24 hours. Therefore, based on CA MTUS guidelines and submitted medical records, the request for retrospective OxyContin is not medically necessary.

Retrospective request for Oxycodone 15mg #180 DOS: 12/7/11: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines discourages long term usage unless there is evidence of "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 non-adherent) 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. Additionally, the recommended opioid dosing should 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. In general, the total daily dose of opioid should not exceed 120 mg oral morphine equivalents. In this case, the treating physician did not document the least reported pain over the period since last assessment, average pain, and intensity of pain after taking the opioid, how long it takes for pain relief, how long pain relief lasts, improvement in pain, and improvement in function. These are necessary to meet the CA MTUS guidelines. Although the current medications are subjectively reported to provide modest relief of pain, and allow for an improved activity level, there is no supporting evidence of objective functional improvement such as measurable decrease in frequency and intensity of pain per the VAS scale. The work status is described as "temporarily totally disabled", which implies a complete lack of functional improvement. In addition, opioid dosing should not exceed 120 mg oral morphine equivalents per day. When all opioid medications are factored in, the injured workers daily morphine equivalent dose is substantially higher than the CA MTUS recommended dose of 120 mg per 24 hours. Therefore, based on CA MTUS guidelines and submitted medical records, the request for retrospective Oxycodone is not medically necessary.

Retrospective request for Baclofen 10mg #120 with 3 refills DOS: 12/7/11: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Baclofen (Lioresal).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63 and 64.

Decision rationale: Per CA MTUS Chronic Pain Medical Treatment Guidelines, Baclofen is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. In addition, the guidelines recommend muscle relaxants be used as an option, using a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief. Furthermore, muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. In this case, the guidelines only recommend use of muscle relaxants for short-term treatment. There is documentation of ongoing treatment with muscle relaxants (Flexeril) since at least 12-22-2014, and continuation for any amount of time does not comply with the recommended guidelines. Furthermore, the submitted medical records failed to provide documentation of a spinal cord injury and/or diagnosis of multiple sclerosis that would support the use of Baclofen. Therefore, based on CA MTUS guidelines and submitted medical records,

the request for retrospective Baclofen is not medically necessary.

Retrospective request for Cymbalta 60mg #30 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16.

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines, Cymbalta (Duloxetine) is an antidepressant in the class called Selective serotonin and norepinephrine reuptake inhibitors (SNRIs). The guidelines recommend Cymbalta be used as an option in first-line treatment of diabetic neuropathy. More studies are needed to determine the efficacy of Duloxetine for other types of neuropathic pain. It has FDA approval for treatment of depression, generalized anxiety disorder, diabetic neuropathy, and fibromyalgia. No high quality evidence is reported to support the use of Duloxetine for lumbar radiculopathy. In this case, the submitted medical records failed to provide documentation regarding signs and symptoms and-or a diagnosis of depression, anxiety, diabetic neuropathy, or fibromyalgia that would support the use of Duloxetine. Therefore, based on CA MTUS guidelines and submitted medical records, the request for retrospective Cymbalta is not medically necessary.