MAXIMUS Federal Services

Case Number:	CM15-0164985		
Date Assigned:	09/02/2015	Date of Injury:	06/03/2001
Decision Date:	10/13/2015	UR Denial Date:	07/22/2015
Priority:	Standard	Application Received:	08/21/2015

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: North Carolina
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 was a 47 year old female, who sustained an industrial injury, June 3, 2001. According to progress note of July 15, 2015, the injured worker's chief complaint was back, hips, legs and neck pain. The injured worker reported the pain control the same. The injured worker's daily function and mood have gotten worse. Pain interference with activities of daily living was 3 out of 10. The injured worker reported rated pain with medications was 3 out of 10 and 1 out of 10 without pain medications. The physical exam noted the neck without masses or significant lymphadenopathy. The lumbar spine had tenderness over the lumbar paraspinals. There was tenderness over the lumbar spine. The Fibromyalgia testing was positive for more than 11 out of 18 tender points. The psychiatric effect was normal. The injured worker was undergoing treatment for lumbar spine fail back syndrome, lumbar spinal stenosis, osteoarthritis in knees, fibromyalgia with myofascial pain syndrome and migraines. The injured worker previously received the following treatments random urine screening on March 18, 2015 and July 15, 2015 was consistent with current medications, current mediations were Tizanidine 4mg 1 every 6-8 hours as needed, Duloxetine 60mg delayed release 1 daily, Flector Patches extended release 1.3% 1 topically every 12 hours, Cambia 50mg powder for solution 1 with 2oz water 2 times daily, Oxycodone 10mg-325mg 1 every 6 hours as needed since September 11, 2014, Lyrica 150mg 2 times daily 1 in the AM and 2 at night; home exercise program. The RFA (request for authorization) dated the following treatments were requested prescriptions for Oxycodone 10-325mg # 30 and Duloxetine 60mg #30. The UR (utilization review board) denied certification on July 22, 2015 for the Oxycodone prescription due to there was one documentation of an opioid

agreement being signed, no urine drug screening or screen for aberrant behavior. The prescription for Duloxetine was denied due to no significant functional benefit or improvement was documented, the injured worker reported functional decline despite medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone/Acetaminophen 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: 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 dairy 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.When to Continue Opioids: (a) If the patient has returned to work (b) If the patient has improved functioning and pain (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004)The long-term use of this

medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function. Therefore all criteria for the ongoing use of opioids have not been met and the request is not certified and therefore is not medically necessary.

Duloxetine 60mg #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation PDR, cymbalta.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. The physician desk reference states the requested medication is indicated in the treatment of fibromyalgia. The patient has the documented diagnosis of symptomatic fibromyalgia. Therefore the request is certified and medically necessary.