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| Case Number: | CM15-0182573 | | |
| Date Assigned: | 09/23/2015 | Date of Injury: | 01/12/2005 |
| Decision Date: | 10/30/2015 | UR Denial Date: | 08/20/2015 |
| Priority: | Standard | Application Received: | 09/16/2015 |

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:

This is a 55 year old male with a date of injury of January 12, 2005. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar post laminectomy syndrome and pain in lower leg joint. Medical records dated June 4, 2015 indicate that the injured worker complains of chronic lower back pain rated at a level of 5 to 6 out of 10 and 7 out of 10 without medications. Records also indicate that the injured worker complains of "Lots of nerve pain". A progress note dated August 4, 2015 notes subjective complaints of constant lower back pain with burning into the posterolateral aspect of the bilateral lower extremities right greater than left, and pain in the left knee. Per the treating physician (August 4, 2015), the employee work status was permanent and stationary. The physical exam dated June 4, 2015 reveals a very antalgic gait, use of a cane, obvious left limping, severe tenderness and tightness across the lumbosacral regions, decreased range of motion more than 90% restricted in all planes, positive straight leg raise bilaterally, and left greater than right hypoesthesia and dysesthesia of the legs. The progress note dated August 4, 2015 documented a physical examination that showed an antalgic gait, use of a cane, and normal muscle tone without atrophy in all extremities. Treatment has included medications (including MS Contin 100mg one to two tablets three times each day since at least May of 2015; Soma 350mg at bedtime and Ambien 10mg at bedtime since at least December of 2014; history of Neurontin), back surgery, and spinal cord stimulator trial. The treating physician documented that the injured worker has recently decreased the Morphine dosage from 900mg per day to 600mg per day. The original

utilization review (August 20, 2015) non-certified a request for a nine month program of medication taper of Morphine from 600mg per day to 120mg per day.

IMR ISSUES, DECISIONS AND RATIONALES

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

9 month program of medication taper of Morphine from 600 mg per day to 120 mg per day: 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 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. (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 non-opioid 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 decrease in objective pain measures such as VAS scores for significant periods of time. There are no objective measures of improvement of function or how the medication improves activities. The work status is not mentioned. The request is for a taper which can be accomplished in less than 9 months. Therefore not all criteria for the ongoing use of opioids have been met and the request is not medically necessary.