

Case Number:	CM15-0187943		
Date Assigned:	09/29/2015	Date of Injury:	11/10/1997
Decision Date:	11/09/2015	UR Denial Date:	09/11/2015
Priority:	Standard	Application Received:	09/24/2015

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 50-year-old male with a date of industrial injury 11-10-1997. The medical records indicated the injured worker (IW) was treated for chronic severe low back pain with bilateral lower extremity pain; recurrent disc lesion, status post lumbar fusion with removal of hardware; myofascial pain-spasm; large disc herniation with severe central stenosis at L3-4; opioid dependency with efficacy but tolerance; and depression due to chronic pain. In the progress notes (9-1-15), the IW reported pain and spasms in the left shoulder, between the shoulder blades, across the low back and in both thighs rated 6 to 7 out of 10. His average pain over the last month was 7 to 8 out of 10, lowest pain was 6 out of 10 and highest pain was 9 out of 10. Medications were stated to improve his ability to tolerate activity and participate in therapeutic exercises. The notes stated that without medications, the IW could walk only short distances, could not groom himself, shower or prepare food, eat, or perform household chores. He could not participate in social activities and was easily upset. With medications, he could walk 30 to 45 minutes, sleep 8 to 10 hours and sustain activity from 30 to 90 minutes; he was also able to perform his own personal care, prepare small meals and perform light household tasks. He stated his medications begin to work within 30 minutes of taking them and lasted 6 to 8 hours. Medications were Celebrex, Dilaudid, Fentora, Opana (since at least 1-2015), Lyrica and Baclofen. An opioid contract was stated to have been signed by the IW. The IW was disabled. On physical exam (8-4-15 and 9-1-15 notes), the IW displayed a slightly forward flexed posture. Range of motion was limited to 75 degrees forward flexion and 15 degrees extension. There was positive Trendelenburg in both hips. Treatments included lumbar discectomy and fusion (2000),

removal of spinal hardware (2001), epidural steroid injections, radiofrequency nerve ablations, physical therapy and medications. A urine drug screen on 8-4-15 was not consistent with prescribed medications. A Request for Authorization was received for Opana 40mg #90. The Utilization Review on 9-11-15 modified the request for Opana 40mg #90 to allow 23 tablets for weaning.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription for Opana 40 mg #90: 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 documentation of significant subjective improvement in pain such as VAS scores. There is no objective measure of improvement in function or activities due to medication. Work status is not mentioned. For these reasons, not all the criteria set forth above of ongoing and continued used of opioids have been met. Therefore, the request is not medically necessary.