

Case Number:	CM15-0189749		
Date Assigned:	10/01/2015	Date of Injury:	12/03/2007
Decision Date:	11/23/2015	UR Denial Date:	09/16/2015
Priority:	Standard	Application Received:	09/25/2015

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: Colorado

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 female with a date of injury of December 3, 2007. A review of the medical records indicates that the injured worker is undergoing treatment for T9 compression fracture, thoracic facet syndrome, thoracic disc desiccation with overlying myofascial pain, multilevel lumbar spondylosis, severe reactive depression, and chronic pain. Medical records dated July 22, 2015 indicate that the injured worker complained of continued significant pain rated at a level of 9 out of 10, with inability to exercise. Records also indicate that the injured worker experiences pain relief with Naproxen and Cyclobenzaprine, and that gastrointestinal issues are reduced with Pantoprazole. A progress note dated September 2, 2015 documented complaints of mid thoracic and upper lumbar pain rated at a level of 9 out of 10, and that she was being seen urgently due to medications being denied. The record also indicates that the injured worker was exercising regularly as of that date. The physical exam dated July 22, 2015 reveals a depressed affect, slow gait, use of a cane, and tenderness throughout the mid and lower thoracic musculature. The progress note dated September 2, 2015 documented a physical examination that showed no changes since the examination conducted on July 22, 2015. Treatment has included thoracic medial branch block (April 14, 2015), four sessions of acupuncture that were not helpful, psychotherapy, and medications (Naproxen 550mg twice a day, Lexapro 20mg once a day, Cyclobenzaprine 7.5mg twice a day as needed, and Pantoprazole 20mg two tablets each day since at least March of 2015; history of Opana and Elavil). The treating physician documented that the urine drug screen dated March 25, 2015 showed "Consistent" results.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #180: 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, criteria for use, Opioids for chronic pain, Opioids, differentiation: dependence & addiction, Opioids, specific drug list.

Decision rationale: The Guidelines establish criteria for use of opioids, including long term use (6 months or more). When managing patients using long term opioids, the following should be addressed: Re-assess the diagnosis and review previous treatments and whether or not they were helpful. When re-assessing, pain levels and improvement in function should be documented. (Information from sources other than patient can also be considered.) Pain levels should be documented every visit. Function should be evaluated every 6 months using a validated tool. Adverse effects, including hyperalgesia, should also be addressed each visit. Patient's motivation and attitudes about pain / work / interpersonal relationships can be examined to determine if patient requires psychological evaluation as well. Aberrant / addictive behavior should be addressed if present. Do not decrease dose if effective. Medication for breakthrough pain may be helpful in limiting overall medication. Follow up evaluations are recommended every 1-6 months. To summarize, the 4A's of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors) have been established. 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) Several circumstances need to be considered when determining to discontinue opioids: 1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of Opioids. 2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to opioids, and aggressive or threatening behavior in clinic. Weaning from the medication over 30 day period, under direct medical supervision, is recommended unless a reason for immediate discontinuation exists. If a medication contract is in place, some physicians will allow one infraction without immediate discontinuation, but the contract and clinic policy should be reviewed with patient and consequences of further violations made clear to patient. 3) Consider discontinuation if there has been no improvement in overall function, or a decrease in function. 4) Patient has evidence of unacceptable side effects. 5) Patient's pain has resolved. 6) Patient exhibits serious non-adherence and misuse (including urine drug testing negative for prescribed substances on 2 occasions). Per the Guidelines, Chelminski defines serious substance misuse as meeting any of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for opioids not routinely prescribed. (Chelminski, 2005) 7) Patient requests discontinuing opioids. 8) Consider verifying that patient is in consultation with physician

specializing in addiction to consider detoxification if patient continues to violate the medication contract or shows other signs of abuse / addiction. 9) Document the basis for decision to discontinue opioids. Likewise, when making the decision to continue opioids long term, consider the following: Has patient returned to work. Has patient had improved function and decreased pain with the opioids. For the patient of concern, the record is contradictory as to patient improvement with treatment regimen which has included Percocet. The treating physician notes at the July 22, 2015 office visit pain level 9/10, and inability to exercise at a time when patient was using Percocet as part of her pain treatment regimen. The treating physician also notes at that visit that the opiates are not effective for patient and weaning schedule has been initiated. The most recent record available for review (also the next date seen) is an office note dated September 2, 2015 in which the treating physician now indicates patient had significant improvement with Percocet and should continue use. Pain is still rated 9/10 at the September office visit, but the notes indicate 50% improvement in pain when taking Percocet. (9/10 pain at visits when patient taking Percocet and 9/10 pain at visits when patient not taking Percocet.) The September 2, 2015 visit record also indicates patient can cook, clean and exercise with Percocet. (July 2015 office visit record indicated patient not exercising even when taking Percocet). While the treating physician does reference the 4 A's of monitoring as being accomplished, the contradictions in the record regarding pain and function improvement with Percocet make it impossible to determine patient's actual response to the use of Percocet. Given the contradictions in the record about improvement in pain and/or function, the Percocet is not medically necessary.