MAXIMUS Federal Services

Case Number:	CM15-0201142		
Date Assigned:	10/16/2015	Date of Injury:	05/06/2009
Decision Date:	11/25/2015	UR Denial Date:	09/15/2015
Priority:	Standard	Application Received:	10/13/2015

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: Montana, Oregon, Idaho
Certification(s)/Specialty: Orthopedic Surgery

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 53-year-old male, who sustained an industrial injury on 5-6-09. The injured worker is currently diagnosed with right elbow internal derangement, right elbow pain, right elbow contusion, right knee internal derangement, right knee meniscal tear, right paracentral disc protrusion at L5-S1, lumbar degenerative disc disease, lumbar facet joint arthropathy, low back pain, lumbar sprain-strain, right knee sprain-strain, right elbow sprain-strain and left knee pain. The injured worker is not currently working. A note dated 8-28-15 reveals the injured worker presented with complaints of bilateral low back pain, right elbow and bilateral knee pain. The pain is worsened by any activity and relieved with medication. Per questionnaire dated 8-5-15 the injured worker experiences difficulty with vigorous and moderate activities, lifting and carrying groceries, climbing stairs, bending, kneeling, stooping, prolonged walking and self-care. Physical examinations dated 7-1-15 and 8-28-15 revealed right knee clicking, popping and buckling. There is tenderness to palpation at the right elbow, right knee and lumbar paraspinal muscles. Range of motion is decreased in the lumbar, thoracic, right elbow and right knee due to pain. The lumbar discogenic, thoracic, right elbow and right knee provocative maneuvers were positive. There are lumbar spasms noted and the nerve root tension signs are negative bilaterally. The injured worker experiences decreased balance with heel-toe walking. He has an altered gait and uses a cane for stabilization. Treatment to date has included right knee arthroscopy with meniscectomy and medication; Oxycodone (3-2014), Cymbalta, OxyContin, Lidoderm patch and medical THC. Diagnostic studies to date have included urine

drug screens. A request for authorization dated 9-5-15 for Oxycodone 10-325 mg #60 is denied, per Utilization Review letter dated 9-15-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Opioids, long-term assessment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain.

Decision rationale: According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. 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. 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. Opioids may be continued if the patient has returned to work and the patient has improved functioning and pain. According to the ODG pain, section a written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent. The lowest possible dose should be prescribed to improve pain and function. Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control is recommended. 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. A major concern about the use of opioids for chronic pain is that most randomized-controlled trials are limited to a short-term period (1 to 6 months), with high rates of dropout due to adverse effects and/or lack of efficacy (as high as 60%). Studies usually exclude patients with mental health disease or substance abuse, limiting generalizability. Methodological issues result in limitations, with problems of studies including insufficiently comprehensive outcome assessment, and incomplete inclusion of adverse effects. Results suggest modest pain relief compared to placebo (approximately 30%), but there are no long-term studies to determine if pain relief is maintained. Overall, the safety of long-term use has not been adequately studied,

and some nonrandomized prospective studies suggest opioid treatment may actually retard functional recovery. This leads to a concern about confounding issues such as tolerance, opioid-induced hyperalgesia, long-range adverse effects such as hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect. In this case, the injured worker was injured in 2009 and has been treated with opioids since 3/2014. Based on the documentation there is insufficient evidence to recommend the chronic use of opioids. There is no documentation of increased level of function, percentage of pain relief, duration of pain relief, or that the injured worker has returned to work. Therefore, the criteria set forth in the guidelines have not been met and the request is not medically necessary.