MAXIMUS Federal Services

Case Number:	CM15-0026410		
Date Assigned:	02/19/2015	Date of Injury:	11/20/2006
Decision Date:	04/07/2015	UR Denial Date:	02/11/2015
Priority:	Standard	Application Received:	02/12/2015

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: California
Certification(s)/Specialty: Emergency Medicine

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 59 year old male sustained a work related injury on 11/2/2006. According to a progress report dated 01/13/2015, the injured worker continued to have pain in the middle of his low back. Pain was constant, dull, throbbing pain. He had constant pain that radiated in the right buttocks and into the posterior thigh to the posterior knee. Without medication his average pain was rated 8 on a scale of 1-10 and with medications his pain was down to 5 and tolerable. With his current medications, he was able to do most of his daily activities. Diagnoses included displacement lumbar disc without myelopathy, degenerative lumbar/lumbosacral intervertebral disc and lumbago. Medications included Opana ER, Gabapentin, Flexeril and Ritalin. Opana IR decreased. On 02/11/2015, Utilization Review non-certified Opana IR 10mg every 6 hours as needed #120, Flexeril 10mg every 8 hours #90 and Opana ER 40mg every 8 hours #90. In regard to Opana ER and Opana IR, there was no specific information reported related to the use of opioids. There was no risk assessment information for the use of controlled substances in this injured worker on chronic high dose of opioids. CA Chronic Pain Medical Treatment Guidelines pages 78-80, 93 and 124 were referenced. In regard to Flexeril, this medication is not recommended to be used for longer than 2-3 weeks. The injured worker had been chronically prescribed this medication which would in general not be appropriate. CA MTUS Chronic Pain Medical Treatment Guidelines pages 63, 64 Muscle Relaxants were referenced. The decision was appealed for an Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Opana IR 10 MG Every 6 Hours As Needed #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; Opioids for chronic pain; Opioids, dosing Page(s): 76-80; 80; 86-87.

Decision rationale: The request is for Opana IR 10 mg every 6 hours, which is an immediate release oral formulation of oxymorphone, an narcotic used for treatment of severe pain. The MTUS guidelines state narcotics appear to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time- limited course of opioids has led to the suggestion of re-assessment and consideration of alternative therapy. Chronic use of opioids requires 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 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. While the treating physician records does state that use of the current medications improves the chronic pain of the injured worker from an 8 out of 10 to a 5 and gives some functional capacity, the records do not clearly address all the necessary factors to satisfy long-term opioid utilization for chronic pain. Furthermore, in general, the MTUS guidelines recommends that dosing of narcotics does not exceed 120 mg oral morphine equivalents per day, and for patients taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. The Morphine Equivalent Dose (MED) for each opioid is used to determine equivalency. In general, the total daily dose of opioid should not exceed 120 mg oral morphine equivalents. Rarely, and only after pain management consultation, should the total daily dose of opioid be increased above 120 m g oral morphine equivalents. The injured worker is utilizing oxymorphone, which has a morphine equivalent of 3 to 1. 10mg every 6 hours is a total daily dose of 40mg, which equals 120mg morphine equivalents. The injured worker also utilizes an extended release formulation of oxymorphone. Together this clearly exceeds the recommended maximum of 120mg daily oral morphine equivalents. There is no clear documentation of pain management consultation or clear rationale to exceed the maximum recommended dosage of morphine equivalents. With the documentation provided, the MTUS guidelines do not support the request as written and it is therefore not medically necessary.

Flexeril 10 MG Every 8 Hours #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64.

Decision rationale: The request is for flexeril, or cyclobenzaprine, which is an antispasmodic utilized for pain. The MTUS guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Cyclobenzaprine is recommended for a short course of therapy for pain relief. Limited, mixed-evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants. Cyclobenzaprine is more effective than placebo in the management of back pain, although the effect is modest and comes at the price of adverse effects. The greatest effect appears to be in the first 4 days of treatment. Side effects include anticholinergic effects (drowsiness, urinary retention and dry mouth). Sedative effects may limit use. This medication is not recommended to be used for longer than 2-3 weeks. The request for ongoing use of a muscle relaxant is not supported by the MTUS guidelines and is therefore not medically necessary.

Opana ER 40 MG Every 8 Hours #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; Opioids for chronic pain; Opioids, dosing Page(s): 76-80; 80; 86-87.

Decision rationale: The request is for Opana IR 10 mg every 6 hours, which is an immediate release oral formulation of oxymorphone, an narcotic used for treatment of severe pain. The MTUS guidelines state narcotics appear to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time- limited course of opioids has led to the suggestion of re-assessment and consideration of alternative therapy. Chronic use of opioids requires 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

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. While the treating physician records does state that use of the current medications improves the chronic pain of the injured worker from an 8 out of 10 to a 5 and gives some functional capacity, the records do not clearly address all the necessary factors to satisfy long-term opioid utilization for chronic pain. Furthermore, in general, the MTUS guidelines recommends that dosing of narcotics does not exceed 120 mg oral morphine equivalents per day, and for patients taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. The Morphine Equivalent Dose (MED) for each opioid is used to determine equivalency. In general, the total daily dose of opioid should not exceed 120 mg oral morphine equivalents. Rarely, and only after pain management consultation, should the total daily dose of opioid be increased above 120 m g oral morphine equivalents. The injured worker is utilizing oxymorphone, which has a morphine equivalent of 3 to 1. 10mg every 6 hours is a total daily dose of 40mg, which equals 120mg morphine equivalents. The injured worker also utilizes an extended release formulation of oxymorphone. Together this clearly exceeds the recommended maximum of 120mg daily oral morphine equivalents. There is no clear documentation of pain management consultation or clear rationale to exceed the maximum recommended dosage of morphine equivalents. With the documentation provided, the MTUS guidelines do not support the request as written and it is therefore not medically necessary.