

Case Number:	CM15-0211471		
Date Assigned:	10/30/2015	Date of Injury:	02/25/2001
Decision Date:	12/11/2015	UR Denial Date:	10/21/2015
Priority:	Standard	Application Received:	10/27/2015

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:

This is a 49 year old female with a date of injury on 2-25-01. A review of the medical records indicates that the injured worker is undergoing treatment for back pain, left knee pain and complex regional pain syndrome of left lower extremity. Progress report dated 10-13-15 reports continued complaints of constant, aching, sharp, shooting, throbbing and burning lower back pain that radiates down the left leg. The pain is rated 7 out of 10 and on average 6 out of 10. The pain improves 100 percent with medications. Objective findings: gait is antalgic, she walks with a cane and she has lumbar spine tenderness. Previous urine drug screen consistent for morphine. She states that with morphine she can walk more than 10 to 15 minutes, perform household chores and without it she cannot walk more than 10 minutes. Treatments include: medication, physical therapy, chiropractic, epidural injections, spinal cord stimulator implantation and cognitive behavior therapy. According to the medical records, she has been taking MS Contin since at least April 2015. Request for authorization dated 10-13-15 was made for MS Contin 60 mg IR 1 Tab BID quantity 56 for 28 Days. Utilization review dated 10-20-15 modified the request to certify Ms Contin 60 mg ER quantity 40.

IMR ISSUES, DECISIONS AND RATIONALES

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

MS Contin 60mg IR 1 Tab BID #56 for 28 Days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Drug testing, Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids for chronic pain, Opioids, dosing, Opioids, specific drug list, Weaning of Medications. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Opioids for Chronic Pain.

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 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. 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. The ODG-TWC pain section comments specifically on criteria for the use of drug screening for ongoing opioid treatment. The ODG (Pain / Opioids for chronic pain) states According to a major NIH systematic review, there is insufficient evidence to support the effectiveness of long-term opioid therapy for improving chronic pain, but emerging data support a dose-dependent risk for serious harms. According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 86, it is recommended that dosing 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. Current studies suggest that the upper limit of normal for opioids prior to evaluation with a pain specialist for the need for possible continuation of treatment, escalation of dose, or possible weaning, is in a range from 120-180 mg morphine equivalents a day. (Ballantyne, 2006) (AMDG, 2007) In this case, the worker is a 49 year old male who was injured in 2001. He is being treated for back pain, left

knee pain and complex regional pain syndrome. He has been taking MS Contin since at least 4/15. Based on the documentation there is insufficient evidence to recommend the chronic use of opioids. There is no documentation a signed narcotic contract or that the injured worker has returned to work. In addition, the worker is taking 120 MED of opioids which is above the recommended limit and there does not seem to be any use of non-narcotic medications to limit the amount of opioids. The current guidelines provide very limited support to recommend treatment of non-malignant pain beyond 16 weeks. Therefore, the criteria set forth in the guidelines have not been met and the request is not medically necessary.