

<b>Case Number:</b>	CM15-0034448		
<b>Date Assigned:</b>	03/02/2015	<b>Date of Injury:</b>	06/16/1997
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	02/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/24/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 64 year old male, who sustained an industrial injury on 6/16/97. He has reported back injury. The diagnoses have included chronic pain syndrome, lumbar degenerative disc disease, lumbar herniated nucleus pulposus without myelopathy and lumbar spondylosis. Treatment to date has included spinal cord stimulator, oral medications and back brace. Currently, the injured worker complains of constant, sharp, throbbing lower back, right hip, right leg, right shoulder and bilateral arm pain. On 1/19/15, the injured worker stated pain is reduced significantly by pain medications and mild palpable spasms are noted bilaterally in lumbar musculature with positive twitch response, severely decreased range of motion of right hip due to pain and positive tenderness to palpation of right greater trochanter. On 2/14/15 Utilization Review submitted a modified certification for MsContin 100mg #90 modified to #32, noting weaning process due to lack of qualitative and quantitative evidence of functional improvement and the daily dose exceeded the recommended daily guidelines. The MTUS, ACOEM Guidelines, was cited. On 2/21/15, the injured worker submitted an application for IMR for review of MsContin 100mg #90 modified to #32.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MS Contin 100mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

**Decision rationale:** The patient presents with chronic low back, right hip, right leg, bilateral arms and right shoulder pain with radicular symptoms. The current request is for MS CONTIN 100MG #90. For chronic opiate use, the MTUS guidelines pages 88 and 89 states, "Pain should be assessed at each visit and function should be measured at 6-month intervals using a numerical scale or validated instrument." The MTUS page 78 also requires documentation of the 4 A's, which includes analgesia, ADLs, adverse side effects, and aberrant behavior. MTUS also requires pain assessment or outcome measures that include current pain, average pain, least pain; intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. The patient prescribed MS Contin since at least 8/21/14. The submitted progress reports state that the patient has about 50% decrease in pain with utilizing medications. The reports continually note that the patient suffers from chronic pain and has "functional improvement with narcotic pain medications therefore according to MTUS the patient is a candidate for continued narcotic pain medication therapy." It was noted that a pain contract is on file, UDS is consistent with medications prescribed and the patient does not exhibit any aberrant behaviors. In this case, recommendation for further use cannot be supported as the treating physician has not provided any specific functional improvement, changes in ADL's or change in work status to document significant functional improvement with utilizing long term opiate medication. MTUS requires that all 4A's including ADL's be addressed for opiate management. The treating physician has failed to provide the minimum requirements as required by MTUS for opiate management. This request IS NOT medically necessary and recommendation is for slow weaning per MTUS.