

<b>Case Number:</b>	CM15-0095340		
<b>Date Assigned:</b>	05/21/2015	<b>Date of Injury:</b>	12/07/2005
<b>Decision Date:</b>	12/03/2015	<b>UR Denial Date:</b>	04/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/18/2015

### 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 46 year old female, who sustained an industrial injury on 12-7-2005. The medical records indicate that the injured worker is undergoing treatment for degeneration of lumbar or lumbosacral intervertebral disc, lumbago, lumbar post-laminectomy syndrome, chronic pain syndrome, lumbosacral radiculopathy, lumbar facet joint pain, myalgia and myositis, and fibromyositis. According to the progress report dated 4-16-2015, the injured worker presented with complaints of low back pain with radiation into her legs. On a subjective pain scale, she rates her pain 5-6 out of 10 with medications and 10 out of 10 without. The physical examination of the lumbar spine reveals severe tenderness over the paraspinal musculature, greatest on left, restricted range of motion, and positive straight leg raise test bilaterally. The current medications are Oxycodone IR (since at least 2014). She reports that the benefit of chronic pain medication maintenance regimen, activity restrictions, and rest continue to keep her pain within a manageable level to allow her to complete necessary activities of daily living. Previous diagnostic studies include x-rays, CT scan, and MRI's of the lumbar spine (12-19-2005, 3-23-2006, 2-23-2009, and 11-22-2010). Treatments to date include medication management and surgical intervention. Work status is not indicated on the 4-16-2015 progress note. The original utilization review (4-22-2015) had non-certified a request for Oxycodone IR 15mg #150 and MRI of the lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone immediate release 15mg quantity 150: 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 for chronic pain, Opioids, long-term assessment.

**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." In this case 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, compliance with urine drug screens, 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.

**MRI of lumbar spine without contrast:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Online edition, MRI.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** According to CA MTUS/(ACOEM), 2nd edition (2004), page 303, Low Back Complaints, Chapter 12, which is part of the California Medical Treatment Utilization Schedule. It states, "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not

respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures)." MRI imaging is indicated when cauda equine syndrome, tumor, infection or fracture are strongly suspected and plain film radiographs are negative. In this particular patient there is no indication of criteria for an MRI based upon physician documentation or physical examination findings from the exam note of 4/6/15. The injury occurred in 2005 and the worker had lumbar spine surgery in 2006. She has most recently had an MRI of her lumbar spine on 11/22/10. There is no documentation of progressive nerve root dysfunction or failure of a treatment program such as physical therapy to suggest a new MRI would reveal significant changes amenable to surgical intervention. The request does not meet criteria set forth in the guidelines and therefore the request is not medically necessary.