

Case Number:	CM15-0240568		
Date Assigned:	12/17/2015	Date of Injury:	03/12/1997
Decision Date:	01/25/2016	UR Denial Date:	11/10/2015
Priority:	Standard	Application Received:	12/09/2015

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 60 year old female who sustained an industrial injury on 3-12-1997. Medical records indicated the injured worker is being treated for fibromyalgia, intervertebral disc degeneration lumbar region, severe depression, and long term (current) use of opiate analgesic. Per the physical medicine and rehabilitation new patient evaluation dated 10-22-2015 the injured worker reports chronic pain in her lumbar spine and chronic bilateral arm pain. The injured worker reports severe whole body pains with frequent fibro attacks that affect her ribs, shoulders, head, neck, and hips with no ability to move and states stress affects this and is the cause. The injured worker reports she has moderate low back pain with referral to the left leg to the knee. The injured worker reports her pain level is a 9 out of 10 and at its best 8 out of 10. The injured worker also reports the Duragesic patch gives her great pain control her first day on it then it wears off some, Norco only gives 1-2 hours of pain relief, and she has tapered Lyrica to 1 at night. The injured worker reports she feels depressed all the time, she does not sleep and is always restless and she notes frequent awakenings and lack of restful sleep for years. The injured worker reports she cannot walk more than 20 minutes, she can lift 20 pounds on a good day, she is not doing errands or house chores, and she can write and type for 10 minutes. On physical exam the physician reports the injured worker has an antalgic gait, her cervical spine has spasm and tenderness on both sides of paravertebral muscles, tenderness at the rhomboids, and sternoclavicular joint, her lumbar spine range of motion is full but guarded and painful, on palpation her paravertebral muscles are tender on both sides, spinous process tenderness noted on L5, pelvic compression test is positive, bilateral shoulders have tenderness in the biceps groove,

periscapular muscles and trapezius, and she has bilateral tenderness of the buttock. The physician reports the injured worker has been on Opioids for years with only partial benefit. The physician states will keep Duragesic for now, recommends the injured worker go off Norco as she has no benefit with usage and will prescribe 10 days worth for use until she can get new med from pharmacy, add Nucynta for control of pain and neuropathic effects, and is requesting pain management counseling. The physician reports the injured worker is permanent and stationary with maximum medical improvement and is permanently disabled. The urine drug screen dated 10-22-2015 was positive for Hydrocodone, Norhydrocodone, Hydromorphone, Fentanyl, Fentanyl metabolite, and THC. Treatment to date for the injured worker includes partial discectomy in 2001, right hip replacement in 12-11-2014, chiropractic treatment (reported did not tolerate), acupuncture (reported did not tolerate), medications Fentanyl 75mcg-hour patches (reported has been on for years), Celexa 40mg (reported taking since at least 11-20-2014), Lyrica 50mg (reported taking since at least 11-20-2014), Norco 10-325mg (reported taking since at least 11-20-2014), Align 4mg, Cymbalta 30mg, and Lodine 300mg. The UR decision dated 11-10-2015 denied the requests for Norco 10-325mg, quantity 40 and Nucynta 75mg, quantity 120.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg, forty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, long-term assessment.

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 60 years old and was injured in 1997. She is being treated for fibromyalgia and chronic low back pain and has been treated with opioids for a prolonged period. Based on the documentation there is insufficient evidence to recommend the chronic use of opioids. There is no documentation of increased level of function, significant percentage of pain relief, duration of pain relief, compliance with urine drug screens that the injured worker has returned to work. 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.

Nucynta 75 mg 120 count: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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 60 years old and was injured in 1997. She is being treated for fibromyalgia and chronic low back pain and has been treated with opioids for a prolonged period. Based on the documentation there is insufficient evidence to recommend the chronic use of opioids. There is no documentation of increased level of function, significant percentage of pain relief, duration of pain relief, compliance with urine drug screens that the injured worker has returned to work. 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.