

Case Number:	CM15-0241864		
Date Assigned:	12/22/2015	Date of Injury:	01/06/1973
Decision Date:	01/25/2016	UR Denial Date:	11/23/2015
Priority:	Standard	Application Received:	12/11/2015

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 70 year old male, who sustained an industrial injury on 1-6-1973. The injured worker was being treated for prostate cancer with bony metastasis. The injured worker (7-14-2015 and 8-18-2015) reports prostate cancer. The injured worker did not report pain in the hips. The physical exam (7-14-2015) reveals an obese abdomen, a normal gait and station of the head and neck. There is no physical exam (8-18-2015) in the provided medical records. The injured worker (10-20-2015) reports lower back pain with joint pain in the joints for the past few days. The treating physician notes that the injured worker has not tried non-steroidal anti-inflammatory drugs. The physical exam (10-20-2015) reveals a normal gait and station of the head and neck. There was no opioid pain contract, risk assessment or any urine drug screen included in the provided medical records. Surgeries to date have included prostate needle biopsy and radical prostatectomy. Treatment has included radiation therapy, hormonal therapy (Degarelix, Firmagon), monoclonal antibody injections, brachytherapy, and pain (Percocet 10mg-325mg since at least 1-2015 to 6-2015) medication. Per the treating physician (10-20-2015 report), the injured worker has not returned to work. The treatment plan includes Ibuprofen 600mg x10 days for hip pain and Oxycodone-APAP 5 mg-325 mg. On 11-23-2015, the original utilization review non-certified a request for Oxycodone-APAP 5 mg-325 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

100 Oxycodone-APAP 5 MG-325 MG for 8 Days Supply: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Opioids, cancer pain vs. nonmalignant 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." The use of opioids is well accepted in treating cancer pain, where nociceptive mechanisms are generally present due to ongoing tissue destruction, expected survival may be short, and symptomatic relief is emphasized more than functional outcomes. In chronic non-malignant pain, by contrast, tissue destruction has generally ceased. Expected survival in chronic pain is relatively long and return to a high level of function is a major goal of treatment. Therefore, approaches to pain developed in the context of malignant pain may not be transferable to chronic non-malignant pain. 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, failure of first line medications, percentage of

pain relief, duration of pain relief, compliance with urine drug screens, a signed narcotic contract or that the injured worker has returned to work. It is unclear whether the provider is attributing his current pain to progression of his cancer or non-malignant conditions based on the submitted documentation, as he was diagnosed with cancer 15 years ago and there is no documented new metastatic lesions. Therefore, the criteria set forth in the guidelines have not been met and the request is not medically necessary.