

Case Number:	CM14-0112446		
Date Assigned:	08/01/2014	Date of Injury:	09/03/1998
Decision Date:	09/26/2014	UR Denial Date:	06/23/2014
Priority:	Standard	Application Received:	07/17/2014

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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 61-year-old male patient who reported an industrial injury to the back on 9/3/1998, 16 years ago, attributed to the performance of his customary job tasks when he was involved in a motor vehicle accident. The patient is being treated for the diagnoses of post laminectomy syndrome lumbar spine; status post anterior cervical discectomy and fusion C4-C7 with nonunion, cervical stenosis at C4-C5, status post removal hardware at L4-L5 with exploration effusion, and status post failed lumbar spine cord stimulator trial. The patient continues to complain of bilateral neck pain, bilateral lower back pain, bilateral upper extended pain, and bilateral lower extremity pain. The patient reportedly has a pain level of 7/10 with the prescribed medications and 10/10 without the medications. The patient is noted to have been increased with his morphine equivalents per day. The patient has also been prescribed gabapentin for neuropathic pain. The patient is prescribed Fentanyl 75 mcg/hr patches #10 and oxycodone 30 mg #120.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl 75mcg Patch #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Page(s): 80-81.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-306, Chronic Pain Treatment Guidelines opioids Page(s): 74-97. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chapter 6 pages 114-116; Official Disability Guidelines (ODG) pain chapter opioids.

Decision rationale: There has been no attempt to titrate the patient down from the high dose of opioids prescribed even though evidence-based guidelines established that the high dose opioid therapy was not medically necessary for the diagnoses cited. It is noted that the daily MED is actually increasing. The prescription for Fentanyl patches 75 mcg/hr #10 for pain is being prescribed as an opioid analgesic for the treatment of chronic back/neck pain. There is objective evidence provided to support the continued prescription of opioid analgesics for chronic back/neck pain based on the objective findings documented. There is no documented sustained significant functional improvement with the currently prescribed Fentanyl patches. The chronic use of Fentanyl patches is not recommended by the MTUS, the ACOEM Guidelines, or the Official Disability Guidelines for the long-term treatment of chronic knee pain. The updated chapter of the ACOEM Guidelines and the third edition of the ACOEM Guidelines stated that both function and pain must improve to continue the use of opioids. The prescription of opiates on a continued long-term basis is inconsistent with the MTUS and the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs and OTC analgesics for the treatment of chronic neck and back pain. Evidence-based guidelines necessitate documentation that the patient has signed an appropriate pain contract, functional expectations have been agreed to by the clinician, and the patient, pain medications will be provided by one physician only, and the patient agrees to use only those medications recommended or agreed to by the clinician to support the medical necessity of treatment with opioids. The ACOEM Guidelines updated chapter on chronic pain states Opiates for the treatment of mechanical and compressive etiologies: rarely beneficial. Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (70 days). This leads to a concern about confounding issues; such as, tolerance, opioid-induced hyperalgesia, long-range adverse effects, such as, hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect. ACOEM guidelines state that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal and eye symptoms; they should be used only if needed for severe pain and only for a short time. The long-term use of opioid medications may be considered in the treatment of chronic musculoskeletal pain, if: The patient has signed an appropriate pain contract; Functional expectations have been agreed to by the clinician and the patient; Pain medications will be provided by one physician only; The patient agrees to use only those medications recommended or agreed to by the clinician. ACOEM also notes, Pain medications are typically not useful in the subacute and chronic phases and have been shown to be the most important factor impeding recovery of function. Evidence-based guidelines recommend chronic back pain: Appears to be efficacious but limited for short-

term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56% (a statistic limited by poor study design). Limited information indicated that up to one-fourth of patients who receive opioids exhibit aberrant medication-taking behavior. The ODG states that chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (70 days). This leads to a concern about confounding issues, such as, tolerance, opioid-induced hyperalgesia, long-range adverse effects, such as, hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect. (Ballantyne, 2006) (Furlan, 2006) long-term, observational studies have found that treatment with opioids tends to provide improvement in function and minimal risk of addiction, but many of these studies include a high dropout rate (56% in a 2004 meta-analysis) (Kalso, 2004). There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain. (Martell-Annals, 2007) (ODG, Pain Chapter). There is no clinical documentation with objective findings on examination to support the medical necessity of Fentanyl patches for the treatment of chronic neck and back pain. There is no provided evidence that the patient has received benefit or demonstrated functional improvement with Fentanyl patches. There is no demonstrated medical necessity for the prescribed Opioids over a prolonged period of time for the cited diagnoses. Such as, Fentanyl 75mcg Patch #10 is not medically necessary.

Oxycodone HCL 30mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Page(s): 80-81.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-306, Chronic Pain Treatment Guidelines opioids Page(s): 74-97. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chapter 6 pages 114-16; Official Disability Guidelines (ODG) chapter on pain, opioids, criteria for use.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines recommends; ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The medical records provided for review do not contain the details regarding the above guideline recommendations. The opportunity for weaning was provided. There is no objective evidence provided to support the continued prescription of opioid analgesics for the cited diagnoses and effects of the industrial claim. There is no documented sustained functional improvement. There is no medical necessity for opioids directed to chronic mechanical neck and back pain. The prescription for Oxycodone is being prescribed as opioid

analgesics for the treatment of chronic back pain and neck pain s/p fusion against the recommendations of the ACOEM Guidelines. There is no objective evidence provided to support the continued prescription of opioid analgesics for chronic back pain 16 years after the initial DOI and for a period of time longer than 6-8 weeks post operatively. There is no demonstrated medical necessity for the continuation of oxycodone for chronic back or neck pain. The chronic use of Oxycodone is not recommended by the MTUS, the ACOEM Guidelines, or the Official Disability Guidelines for the long-term treatment of chronic pain and is only recommended as a treatment of last resort for intractable pain. The prescription of opiates on a continued long-term basis is inconsistent with the CA MTUS and the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs for the treatment of chronic pain. The current prescription of opioid analgesics is not consistent with evidence-based guidelines based on intractable pain. The ACOEM Guidelines updated chapter on chronic pain states Opiates for the treatment of mechanical and compressive etiologies: rarely beneficial. Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (70 days). This leads to a concern about confounding issues; such as, tolerance, opioid-induced hyperalgesia, long-range adverse effects, such as, hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect. ACOEM guidelines state that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal and eye symptoms; they should be used only if needed for severe pain and only for a short time. The long-term use of opioid medications may be considered in the treatment of chronic musculoskeletal pain, if: The patient has signed an appropriate pain contract; Functional expectations have been agreed to by the clinician and the patient; Pain medications will be provided by one physician only; The patient agrees to use only those medications recommended or agreed to by the clinician. ACOEM also notes, Pain medications are typically not useful in the subacute and chronic phases and have been shown to be the most important factor impeding recovery of function. There is no demonstrated medical necessity for the continued prescription of oxycodone 30 mg #120. Such as, Oxycodone HCL 30mg #120 is not medically necessary.