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| Case Number: | CM14-0163840 | | |
| Date Assigned: | 10/08/2014 | Date of Injury: | 09/03/1999 |
| Decision Date: | 11/04/2014 | UR Denial Date: | 09/16/2014 |
| Priority: | Standard | Application Received: | 10/06/2014 |

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 Ohio. 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:

The injured worker is a 53 year old male with a date of injury of 1/31/1999 at which time he sustained a back injury. Based on symptoms and radiography, he underwent an L4-L5 fusion with pedicle screw fixation on 9-28-2000. Over the years he has had worsening back pain with left sided radiculopathy and developed a left foot drop and consequently has had an escalation of opioid therapy. An MRI scan of the L/S spine from 2013 revealed evidence of a prior fusion and moderated degenerative disc disease at L3-L4 and L4-L5 with moderate stenosis. The diagnoses include failed fusion, L5-S1 spondylolisthesis, lumbar disc displacement, left foot drop, L5-S1 pseudoarthrosis, and neurogenic claudication. The physical exam reveals absent patellar reflexes, diminished sensation in the left L5 dermatome distribution, positive straight leg raise testing bilaterally, moderate weakness of the left extensor hallucus longus, diminished lumbar range of motion, and tenderness to palpation with spasm of the lumbar regions. The pain scores are rated at 10/10 without medications and 2-3/10 with medications. The treating physician notes that the injured worker is prostrate and in bed until his medication begins to work and therefore he is more functional with the medication. The oxycodone quantities are frequently modified by the utilization review physicians, but the prescriber continues with the same quantity every month (#168) and the injured worker fills his prescription under his private insurance.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 10mg #168: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Norco; Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The referenced guideline make the following statements regarding requirements for chronic opioid therapy (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: 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. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: 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 nonadherent) 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. In this instance, it may be argued that there is improved pain and function as a result of the chronic opioid therapy. However, the documentation does not reflect that the lowest possible doses of opioids have been prescribed to improve pain and function. There has been a gradual escalation in opioid therapy over the years seemingly without any attempts to try lower doses. This is particularly an issue as current opioid doses are far in excess of the usually recommended maximum of 120 morphine equivalents per day. The treating physician has repeatedly circumvented any efforts to wean the oxycodone. On 7-15-2014 the utilization review physician modified the request for #168 oxycodone tablets (10 mg) to #126 tablets. That would have afforded an excellent opportunity to assess the injured worker's response to a modest reduction in overall opioid therapy. Oxycodone 10mg #168 is not medically necessary.