

<b>Case Number:</b>	CM14-0218370		
<b>Date Assigned:</b>	01/08/2015	<b>Date of Injury:</b>	10/21/2001
<b>Decision Date:</b>	03/11/2015	<b>UR Denial Date:</b>	12/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2014

### 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. 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: California

Certification(s)/Specialty: Family Practice

### 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 51-year old drugstore employee reported a work-related injury dated October 21, 2001. The mechanism of injury is not described in the available records. Treatment has included a global spinal fusion from L5-S1 with subsequent removal of hardware, placement and re-positioning of a spinal cord stimulator, a functional recovery program, and multiple medications, including long term use of several opioids. Although her initial doses were much higher, she appears to have been on a 50 mcg Fentanyl patch every 48 hours from 4/8/14 to at least 10/2/14, and on Percocet 10/325 eight per day for at least the same time period, and possibly much longer. When her Percocet was denied in UR, the patient continued to fill the prescription through Medicare. Her primary treater started extended release morphine 15 mg twice per day on 7/21/14, with the stated purpose of weaning the patient off her Fentanyl. The doses of Fentanyl and Percocet had not changed as of 10/27/14, but per a 12/8/14 note from her primary treater, she had completely discontinued the Fentanyl. She has started using medical marijuana prescribed by another physician. She continues to take 8 Percocet 10/325 per day, which the provider describes as "a modest dose". Current diagnoses include lumbar radiculopathy, myalgia and myositis, postlaminectomy syndrome of the lumbar spine and shoulder joint pain. The patient is not working and appears to be minimally functional. A 4/22/14 AME report describes her activities as mostly involving lying in bed, watching TV, sitting in her back yard and talking to her daughter. She lives with a daughter and a caretaker. The patient's walker broke and has not been repaired, so she walks with a cane. She has frequent falls, which her provider attributes to her back injury. None of the primary treater's notes document any functional goals, or any

specific improvement in function since well before the patient started extended release morphine. The provider frequently notes that the patient's pain levels decrease slightly with various activities while she is taking pain medications, and remain at a severe (10/10 level) if she is not taking medications. However, there is no description of any activity that she is able to perform or to perform at a higher level due to taking her medications. A request for morphine 15 mg extended release #60 and for Percocet 10/325 mg #235 was modified by Utilization Review (UR) on December 8, 2014. The UR physician utilized the California MTUS and the Official Disability Guidelines in the determination. The UR physician spoke with the injured worker's provider and the provider indicated that he had done his best in weaning the injured worker from a much higher opioid medication and thought it would be extremely hard to further wean the injured worker without increased the chronic pain significantly, however, the injured worker's provider agreed with the UR physician's modification of Percocet and morphine to allow for weaning. A request for Independent Medical Review (IMR) was initiated on December 30, 2014. The documentation submitted for IMR included medical documentation from July 21, 2014 through December 17, 2014. The 12/17/14 note stated that the patient has chronic pain issues that forcing this patient to go off her pain medications would lead her to desperate mental status. The treating physician states that it would not surprise him if the desperation lead to a suicide. The physician noted that he had actually weaned the patient down to about one third of the opioid dose she was on a year prior. The evaluating physician noted that the injured worker signed an opiate agreement and that urine toxicology reports have been appropriate.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Morphine 15mg extended release #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids, dosing. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, page 60; Criteria for use of Opioids, pages 76-77; Opioids for neu.

**Decision rationale:** According to the first guideline cited above, medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. The remaining guidelines state that opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine in the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Specific functional goals should be set, and continued use of opioids should be contingent on meeting these goals. Opioids should be discontinued if there is no improvement in function or if there is a decrease in function. Opioids are not recommended as first-line therapy for neuropathic pain. The response of neuropathic pain to drugs may depend on the cause of the pain. There are very limited numbers of studies that involve opioid treatment for chronic lumbar root pain. A recent study found that chronic radicular lumbar pain did not respond to opioids in doses that have been effective for

painful diabetic neuropathy and postherpetic neuralgia. Patients who have been taking opioids for over 6 months should be periodically reassessed. The reassessment should include documentation of pain and functional improvement compared to baseline. A pain treatment agreement is recommended for long-term opioid use. One of its provisions should be that only one provider gives prescriptions for opioids. The clinical findings in this case do not demonstrate that any of the above guidelines have been followed. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. A diagnosis of lumbar radiculopathy suggests that the patient's pain is at least in part neuropathic. Neuropathic pain does not necessarily respond well to opioids. No assessment was documented as to whether or not opioid use was likely to be helpful in this patient, or of her potential for abuse. She has a family history of alcoholism, which might suggest potential for abuse, as would her smoking, her obesity (BMI 35) and her use of marijuana prescribed by a second provider. (This would be in direct conflict with most pain contracts.) No specific functional goals were set or followed. Most importantly, long-acting morphine was not discontinued when it became clear that it has not produced any functional improvement. There is no documentation of any improvement in this patient's level of function from 7/21/14 to 12/10/14. She remains off work, and appears to have only minimal functional abilities. This is more than adequate evidence that this patient is not responding appropriately to this medication, and that it should be discontinued. This provider's statement that the patient may commit suicide if her medications are not approved is more of a threat than an evidence-based rationale. If he is seriously concerned about the possibility of suicide, he should arrange for urgent psychiatric consultation and/or admission. Based on the evidence-based guidelines cited above, and the clinical documentation provided for my review, morphine ER 15 mg #60 is not medically necessary for this patient. It is not medically necessary because of the lack of appropriate documentation of the patient's status prior to beginning it, because of the failure to set and monitor functional goals, because of failure to address the potential for abuse implied by the patient using marijuana prescribed by another provider, and because of the failure to discontinue it when it became clear that it has not produced any functional recovery.

**Percocet 10/325mg #235:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines when to continue opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-opioids for chronic pain

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, page 60; Criteria for use of Opioids, pages 76-77; Opioids for neu.

**Decision rationale:** Percocet 10/325 is brand-name oxycodone 10 mg combined with 325 mg acetaminophen. Oxycodone is an opioid analgesic. According to the first guideline cited above, medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. The remaining guidelines state that opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine if the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for

abuse. Specific functional goals should be set, and continued use of opioids should be contingent on meeting these goals. Opioids should be discontinued if there is no improvement in function or if there is a decrease in function. Opioids are not recommended as first-line therapy for neuropathic pain. The response of neuropathic pain to drugs may depend on the cause of the pain. There are very limited numbers of studies that involve opioid treatment for chronic lumbar root pain. A recent study found that chronic radicular lumbar pain did not respond to opioids in doses that have been effective for painful diabetic neuropathy and postherpetic neuralgia. Patients who have been taking opioids for over 6 months should be periodically reassessed. The reassessment should include documentation of pain and functional improvement compared to baseline. A pain treatment agreement is recommended for long-term opioid use. One of its provisions should be that only one provider gives prescriptions for opioids. The clinical findings in this case do not demonstrate that any of the above guidelines have been followed. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. The diagnosis of lumbar radiculopathy suggests that the patient's pain is at least in part neuropathic. Neuropathic pain does not necessarily respond well to opioids. No assessment was documented as to whether or not opioid use was likely to be helpful in this patient, or of her potential for abuse. She has a family history of alcoholism, which might suggest potential for abuse, as would her smoking, her obesity (BMI 35) and her use of marijuana prescribed by a second provider. (This would be in direct conflict with most pain contracts.) No specific functional goals were set or followed. Most importantly, Percocet was not discontinued when it became clear that it has not produced any functional improvement. There is no documentation of any improvement in this patient's level of function from 4/22/14 to 12/10/14. She remains off work, and appears to have only minimal functional abilities. This is more than adequate evidence that this patient is not responding appropriately to this medication, and that it should be discontinued. This provider's statement that the patient may commit suicide if her medications are not approved is more of a threat than an evidence-based rationale. If he is seriously concerned about the possibility of suicide, he should arrange for urgent psychiatric consultation and/or admission. Based on the evidence-based guidelines cited above, and the clinical documentation provided for my review, Percocet 10/325 #235 (or #240 as originally requested) is not medically necessary for this patient. It is not medically necessary because of the lack of appropriate documentation of the patient's status prior to beginning it, because of the failure to set and monitor functional goals, because of failure to address the potential for abuse implied by the patient's use of marijuana prescribed by another provider, and because of the failure to discontinue it when it became clear that it has not produced any functional recovery