

Case Number:	CM15-0175627		
Date Assigned:	09/16/2015	Date of Injury:	12/02/2012
Decision Date:	10/23/2015	UR Denial Date:	08/07/2015
Priority:	Standard	Application Received:	09/04/2015

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: North Carolina

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:

The injured worker is a 62 year old female who sustained an industrial injury on 12-02-2012. According to a progress report dated 06-16-2015, the injured worker had undergone a left L4 and L5 transforaminal epidural steroid injection on 06-12-2015. Since then, the injured worker noted mild improvement in her back and leg pain. Current back pain was rated 5 on a scale of 1-10, left greater than right with some radiation to her left leg, into her buttocks, down the posterior thigh and into the calf. She did note some mild centralization of her leg pain. There was numbness and tingling in the same distribution, "mildly" improved from prior. Since her last visit, she had initiated a trial of Cymbalta. She continued to wean down on her Percocet and was currently taking 5-325 mg three times a day. She avoided the use of Celebrex due to some bladder symptoms that was similar to the side effects that she had with Advil. She continued to take Lyrica. Medications included Percocet, Celebrex (not currently taking), Protonix, Lidoderm patch, Lyrica and Cymbalta. Impression included grade 1 L4-L5 spondylolisthesis with left L4 and L5 radicular pain and probable left hip osteoarthritis versus labral tear. The provider noted that gradual weaning of Percocet would continue, decreasing her from 5-325 mg three times a day #90 (last month's allotment) down to 5-325 mg twice a day to three times a day as needed #75. She could resume Celebrex as needed. She was to continue Lidoderm Cymbalta and Protonix. Random urine drug screen was reviewed. The results were not documented in this 06-16-2015 progress report. She was to return for follow up in 1 month. A urine drug screen report dated 05-14-2015 was submitted for review and was positive for Buprenorphine and Oxycodone. According to a progress report dated 07-23-2015, the injured working was working

and tolerating her work "well". She did have intermittent flares of pain and had one episode of dizziness or loss of equilibrium. Current medications included Lyrica, Cymbalta, Celebrex as needed, Protonix and Percocet 5-325 mg two to three times daily. She was to continue her medications. Terocin patch was to be trialed in place of the Lidoderm patch. She was to minimize Percocet. She was to return in four weeks. An authorization request dated 07-29-2015 was submitted for review. The requested services included Terocin patches, Lyrica 100 mg, Lyrica 25 mg, Cymbalta, Celebrex, Protonix and Percocet 5-325 mg #120. On 08-07-2015, Utilization Review non-certified the request for Percocet 5-325 mg #75.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 5/325mg, #75: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (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. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control. (h) 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. When to Continue Opioids (a) If the patient has returned to work, (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is documented significant improvement in VAS scores for significant periods of time. There are objective measurements of improvement in function or activity specifically due to the medication as evidenced by the fact the patient is working full time. Therefore, all criteria for the ongoing use of opioids have been met and the request is medically necessary.