

Case Number:	CM15-0177945		
Date Assigned:	09/18/2015	Date of Injury:	02/19/2007
Decision Date:	10/21/2015	UR Denial Date:	09/04/2015
Priority:	Standard	Application Received:	09/09/2015

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 47 year old male who sustained an injury on 2-19-07 resulting when he lifted a table and developed low back pain and inguinal hernia. He had hernia repair and a lumbar laminectomy at two levels in 2007. Treatment for his low back injury included physical therapy, injections, and medication. Diagnoses are chronic back pain and lumbar radiculopathy. Diagnostic tests included MRI lumbar spine on 3-29-13. The medication Oxycodone 5 mg 1 tablet daily was noted on 4-16-15 and he was to continue trial tapering four times a day to every day for breakthrough pain. Urine toxicology screenings were collected on 4-16-15 showed negative for Oxycodone. On 8-20-15, he complains of lower back pain rated with medications as 5 out of 10; quality of sleep is poor and his activity level has remained the same. His medications are working well without any side effects noted. He is scheduled for an MRI lower back on 8-25-15. Medications listed are Gabapentin 400 mg; Lexapro 20 mg; Ibuprofen 800 mg; Omeprazole 20 mg; Oxycodone 5 mg 1 tablet daily; and Baclofen 10 mg. The physical examination reveals antalgic gait without use of assistive devices. Range of motion is restricted with flexion limited to 37 degrees limited by pain; extension limited to 27 degrees; right lateral bending 15 degrees; left lateral bending 15 degrees and lateral rotation to the left and right 30 degrees. Tenderness on palpation paravertebral muscles, spasm on both sides; lumbar facet loading is positive; straight leg raising test was positive on both sides. He is currently working. When he takes the medications he rates his pain 4-5 out of 10 and in the past week the pain was as high as 10 causing him headaches. Treatment plan included tapering Oxycodone 5 mg four times a day every day to every day as needed for breakthrough pain. With medications, he is

able to lift 10-15pounds, walk 5 blocks, sit 60 minutes and stands 30 minutes; perform household tasking including cooking, cleaning, self-care, laundry, grocery shopping for approximately 30 minutes at a time. Current requested treatments Oxycodone 5 mg #30 with 1 refill. Utilization review 9- 3-15 requested treatment was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 5mg #30 with 1 refill: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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 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. (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 documentation of significant subjective improvement in pain such as VAS scores decreasing from a 10/10 to a 4/10. There is objective measure of improvement in function or activities due to medication. Work status is not currently working. For these reasons, all the criteria set forth above of ongoing and continued used of opioids have been met. Therefore, the request is medically necessary.