

Case Number:	CM15-0178834		
Date Assigned:	09/21/2015	Date of Injury:	12/27/1999
Decision Date:	10/22/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/11/2015

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 59 year old female who sustained an industrial injury on 12-27-1999. Diagnoses include post laminectomy syndrome, hip bursitis, lumbar disc degenerative disease, low back pain, sacroiliac pain, myalgia and myositis, right buttock-low back pain consistent with right greater trochanteric bursitis and sacroiliac pain, and lumbar laminectomy. A physician progress note dated 08-20-2015 documents the injured worker has complaints of low back pain that radiated down his right leg and rates his pain as 8 out of 10 on the pain scale with medications and without medications his pain is 10 out of 10. Her quality of sleep is poor. Lumbar range of motion is restricted. On palpation paravertebral muscles, spasm, tenderness and tight muscle band is noted on both sides. Faber test is positive on the right. She has tenderness to palpation over the right greater trochanter and right posterior superior iliac spine. There are numerous myofascial points of tenderness in her buttocks, and paraspinals. She has right lower extremity shaking. She remains largely unchanged. Her current medications continue to moderately control her pain. The physician documents he is unable to wean her medications at this point. Duragesic allow her increased activity tolerance such as cooking, cleaning, gardening and walking up to three blocks. Without her medications she is in bed most of the day crying and shaking and has had 3 Emergency Department visits. A progress note dated 05-04-2015 documents the injured worker has continued back pain that radiates to her right leg. She rates her pain as 8 out of 10 with her medications and 10 out of 10 without medications. Quality of sleep is poor. She states her medications are working well. On this date she reports her Duragesic patch is too expensive and is requesting an alternative. She is also taking Norco for

breakthrough pain. She has right lower extremity shaking, she states it is secondary to pain. She has an antalgic gait and is assisted by a cane and wheelchair. She has trialed MS Contin, which was ineffective. Will trial Oxymorphone ER. Treatment to date has included diagnostic studies, medications, and surgery. A urine drug screen done on 02-10-2014 was consistent per the provider. Current medications include Duragesic 50mcg per hour patch, Norco, Oxymorphone ER, Lidoderm patches, Neurontin, Zanaflex and Bisacodyl, Miralax, Protonix, Paxil and Wellbutrin XL. A Request for Authorization dated 08-20-2015 is for Duragesic 50mcg #15 (refill x1), and Norco 10/325mg #120 (refill x1). On 08-27-2015 Utilization Review non-certified the request for Duragesic 50mcg #15 (refill x1), and Norco 10/325mg #120 (refill x1).

IMR ISSUES, DECISIONS AND RATIONALES

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

Duragesic 50mcg #15 (refill x1): Upheld

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 non-opioid 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 no documented significant improvement in VAS scores for significant periods of time decreasing only to a 8/10 with medications from a 10/10. There are no objective measurements of improvement in function or activity specifically due to the medication. Therefore not all criteria for the ongoing use of opioids have been met and the request is not medically necessary.

Norco 10/325mg #120 (refill x1): Upheld

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 non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses

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