

<b>Case Number:</b>	CM15-0127271		
<b>Date Assigned:</b>	08/05/2015	<b>Date of Injury:</b>	06/29/1999
<b>Decision Date:</b>	10/02/2015	<b>UR Denial Date:</b>	06/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/01/2015

### 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: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 industrial injury on June 29, 1999. Documentation states that the injured worker's past medical history included a fall from a two story building approximately 30 feet to the ground injuring his back and neck in 1999. He underwent L4-5, L5-S1 fusion in 1990. He also had an intrathecal delivery system implanted due to chronic, severe and intractable pain. According to a progress report dated May 27, 2015, chief complaints included back pain and neck pain. The injured worker was seen for pharmacological re-evaluation; pump analysis, dose check and reprogramming. He felt that he was doing well but had not quite caught up on his pain relief due to the decrease in his intrathecal Fentanyl earlier in the month. He went from approximately 2,000 to 2,050 mcg per day of intrathecal Fentanyl without adverse effects. He was at over 3,000 mcg per day and wanted to continue titrating up to improve his functional capacity. His primary care physician had retired and the new practitioners were not ordering the Morphine and Vicodin that he was taking on a non-industrial basis. The injured worker reported neck and back pain that was described as stabbing and burning. Pain level was rated 8 on a scale of 1-10 with medications. Physical examination demonstrated decreased range of motion in the cervical and lumbar spine. He ambulated with a cane. Sensory examination demonstrated decreased touch over the anterolateral thighs in particular. Neurological and psychological exam was appropriate. The intrathecal pump was reprogrammed with Fentanyl 2,800.7 mcg per day and Clonidine 140.03 mcg per day. Diagnoses included lumbosacral spondylosis, spondylolisthesis, post-laminectomy syndrome lumbar, lumbago, degeneration of cervical disc, post-laminectomy syndrome thoracic and cervicalgia. The pump

was advanced 12% in efforts to decrease pain and increase functional capacity. The injured worker was no longer getting Morphine or Vicodin from his private physician for his various pains. The provider noted that Morphine Sulfate IR would begin to be titrated down. The injured worker reported that he was self-procuring the Morphine Sulfate IR and he was advised that he was not to self-procure medication ordered by that office unless the insurance carrier denied authorization. The injured worker's total pain related impairment score was 62 indicating severe impairment for activities of daily living. The treatment plan included advance intrathecal Fentanyl 12% to 2,800.7 mcg per day, advance intrathecal Clonidine 12% to 140.03 mcg per day, decrease Morphine Sulfate IR to one tablet twice a day as needed for pain and withdrawal #30, blood draw for drug screen to determine if injured worker's serum opioid concentrations were within expected steady state range and to ensure patient compliance with opioid agreement and return in one month for re-evaluation and pump refill. Currently under review is the request for advance intrathecal Fentanyl to 2800.7 mcg per day and intrathecal clonidine to 140.03 mcg per day.

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

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

**Advance intrathecal Fentanyl to 2800.7mcg/day and intrathecal clonidine to 140.03mcg/day:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-97.

**Decision rationale:** According to the MTUS Chronic Pain Medical Treatment Guidelines section on Opioids, On-Going Management, p 74-97, (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 injured worker'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 injured worker'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 injured workers 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 injured worker 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 injured worker 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. Additionally, the MTUS states that continued use of opioids requires (a) the injured worker has returned to work, (b) the injured worker has improved functioning and pain. There is current documentation of baseline pain, pain score with use of opioids, functional improvement on current regimen, side effects and review of potentially aberrant drug taking behaviors as outlined in the MTUS and as required for ongoing treatment. Therefore, at this time, the requirements for treatment have been met and are medically necessary.