



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 4-7-09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

OxyContin 40 mg 2 tabs bid

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

American Board of Physical Medicine and Rehabilitation

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Office visits by MD.
- 8-6-04 MD., Required Medical Evaluation.
- 9-27-04 MRI of the lumbar spine.
- Office visits and chiropractic therapy by DC.
- 11-3-04 Psychological evaluation.
- Office visits by DO.
- 3-14-05 MD., office visit.
- MD., office visits.
- MD., office visits from 8-18-08 through 2-3-09, 7 visits.
- 10-14-08 MD., Required Medical Evaluation.
- 10-17-08 EMG/NCS performed by MD.
- 10-20-08 MRI of the lumbar spine.
- 10-27-08 Dr. provided an addendum report.
- 2-16-09 MD., performed a Utilization Review.
- 2-23-09 DO., performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

Follow up visits from unknown provider - hand written notes from xx-xx-xx notes the claimant is seen for follow-up due to neck pain and low back pain, with increased anxiety. The claimant was treated with OxyContin and underwent lumbar epidural steroid injections.

On 6-16-04, the claimant was evaluated by MD. The claimant reported persistent low back pain with radiation to both lower extremities. The claimant has an antalgic gait, midline and bilateral lumbosacral paraspinous discomfort on palpation and percussion.

The claimant is continued on medications to include OxyContin 40 mg, Lortab, 10/500, Xanax, Soma, Celebrex, Prevacid, Zostrix, Sinequan, and Senna.

A Required Medical Evaluation performed by MD., dated 8-6-04 the evaluator felt the claimant's prognosis for any type of somatic or functional improvement with additional treatment is severely limited. The evaluator reported that other than for appropriate oral medications, the evaluator saw no indication for additional supervised medical treatment. The evaluator reported the claimant's physical presentation is so grossly non-physiologic; the evaluator was unable to determine whether or not the claimant does in fact have significant ongoing difficulties. The evaluator noted the claimant had a solid fusion; he was at minimum capacity of returning to sedentary work. The evaluator did not see a clear indication for the massive amount of narcotic pain medications the claimant is currently receiving. The evaluator did not see the indication for the massive amount of OxyContin and multiple other medications. The evaluator felt that the provision of Hydrocodone 10 mg was appropriate. The evaluator felt that the use of Cyclobenzaprine was also indicated.

On 9-25-04, the claimant was admitted to the hospital for pain management. The claimant reported he ran out of medications for two weeks prior to admission. The claimant was provided with PCA pump and Valium for muscle spasms and control of blood pressure with oral anti-hypertensive.

On 9-27-04, an MRI of the lumbar spine shows moderate changes of spondylosis along with osteoarthritis at the L5-S1 level. Small marginal osteophytes appear to cause mild narrowing of the left neural foramen at this level. Post surgical changes involving the lower lumbar spine. Small hemangioma within the L1 and L2 vertebral bodies.

The claimant underwent an initial behavioral medical evaluation on 10-13-04. The evaluator noted the claimant is suffering from a chronic pain disorder with emotional distress symptoms. The claimant also has some depression, anxiety, and stress. The evaluator recommended three hours of psychological testing to assess the levels of depression and stress and make the appropriate recommendations.

Medical record reflects the claimant started chiropractic therapy under the direction of DC., on 10-12-04.

Psychological evaluation on 11-3-04 notes the following diagnosis: AXIS I: Pain disorder associated with both psychological factors and general medical condition, mood disorder due to general medical condition. AXIS II: No diagnosis. AXIS III: Injury and chronic pain in low back and neck. AXIS IV: Severe, medical or health related stress, problems related to social environment, occupational problems, and economic problems. AXIS V: GAF 50. The evaluator recommended evaluation of psychotropic medication due to ineffectiveness, individual psychotherapy, and biofeedback sessions.

Medical records reflect the claimant began a course of psychotherapy.

On 12-2-04, the claimant was evaluated by DO., due to headaches, neck pain, upper back pain, bilateral upper extremity pain, mid back pain, low back pain, bilateral hip pain and bilateral lower extremity pain. The claimant had been provided with trigger point and lumbar facet injections in the past, which have helped the most. The evaluator recommended lumbar facet injections and manipulation under anesthesia.

Follow-up with Dr. notes the claimant the recommendation for caudal epidural steroid injections to the cervical spine, thoracic spine, lumbar spine and sacrum.

On 3-14-05, the claimant was evaluated by MD. The claimant was admitted at Hospital for detoxification from pain medication and treatment of pain and depression.

Medical records reflect that in April 2005, the claimant was evaluated by Dr. who recommended caudal epidural steroid injections.

Medical records reflect the claimant began a course of chronic pain management program in May 2005. The claimant was continued with medications to include Lortab 500, Xanax, Cymbalta, Duragesic patch and Sinequan.

The claimant continued with chiropractic treatments through 2006.

The claimant then came under the care of MD., on 8-18-08. The claimant reports long-term lumbar pin with four failed back surgeries. The claimant's medications included Oxycodone 40 mg, Xanax 2mg, and Doxepin. The claimant reports severe muscle spasms. Diagnosis provided: Chronic pain, failed back syndrome. The evaluator recommended the claimant discontinue smoking, consultation with High Point pain management, and prescription for Amrix to decrease pain and muscle spasms.

Follow-up visit with MD., dated 9-23-08 notes the claimant continues to complain of lumbar spine. The claimant reported that Amrix was not filled for spasms. The claimant reports anxiety secondary to pain. The evaluator provided the claimant with a prescription for OxyContin, Sinequan, and Alprazolam.

A Required Medical Evaluation performed by MD., dated 10-14-08 notes that given the extent of the surgical treatment that the claimant has undergone, he would be surprised if he did not have some degree of ongoing lower back pain. However, the claimant's physical presentation is so non-physiologic. The evaluator reported that given the claimant's poor symptomatic and functional response total previous treatment, ODG did not support any additional supervised medical treatment. The evaluator recommended the claimant be weaned off his current use of medications and this would probably take up to six months and twelve follow-up visits with a specialist to wean him from these medications. The evaluator felt that there are significant social and psychological factors responsible of the claimant's current condition.

On 10-17-08, an EMG/NCS performed by MD., was essentially normal.

An MRI of the lumbar spine dated 10-20-08 showed degenerative disc at L1-L2 without significant impact on the neural elements. Postoperative change of the lumbosacral junction with enhancing granulation tissue at this site.

On 10-27-08, Dr. provided an addendum report. He reviewed additional diagnostic testing performed after his last evaluation and discussed with the claimant that there was no specific explanation for the magnitude of the claimant's lumbar radicular symptoms.

On 11-6-08, the claimant is provided with a refill of medications. Hand written notes.

On 12-10-08, the claimant was evaluated by Dr. The claimant complains of lumbar pain. On exam, the claimant has fatigue, muscle spasms and sexual discomfort. Diagnosis provided: Lumbar radiculopathy and failed back syndrome. The claimant is provided with a prescription for OxyContin, Sinequan and Alprazolam. A controlled substance prescription agreement is signed.

On 1-7-09, the claimant was evaluated by Dr.. The claimant complains of lumbar and thoracic spasms, myofascial pain syndrome and request reinjection with trigger point injections. The evaluator continued the claimant with OxyContin, Sinequan and Alprazolam. The evaluator requested trigger points when approved by workers compensation.

On 2-3-09, the claimant was evaluated by Dr.. He needs a letter for workers compensation for trigger points. He complains of bad back pain and needs his refills. The claimant is provided with a refill for Alprazolam, Norco and Doxepin.

On 2-9-09, the claimant was evaluated by Dr.. Hand written notes. The claimant is continued with is current medications. The claimant rates his pain as 9 with medications. A controlled substance prescription agreement is signed.

On 2-12-09, MD., performed a Designated Doctor Evaluation. The claimant reports the claimant sustained a work related injury. He was unloading a large industrial type waste bin when apparently this was winched off a truck causing the front wheels to be elevated off the ground. The cord snapped and/or slipped, causing the truck to pitch forward violently bouncing the claimant up and down, three times, striking his head on the ceiling of the cab. The claimant had immediate onset of both cervical and lumbar pain. He had immediate onset of weakness and numbness of both upper and lower extremities. The claimant had workup initially for the lumbar spine. The first MRI of the lumbar spine was initially obtained on 4-19-92, which showed a mild to moderate bulge at L5-S1. An MRI of the cervical spine was also performed, which was within normal limits. On 11-4-92, Dr. performed an EMG/NCS showed chronic L5 radiculopathy but no acute radiculopathy. EMG/NCS performed on 2-23-94 demonstrated the same findings, as well as the EMG/NCS performed on 10-20-96. The claimant also complained of left upper extremity numbness and tingling, as well as cervical pain.

However, most of the focus had been primary the lumbar spine and his lower extremity sensory loss. Ultimately, the claimant underwent several surgeries. On 7-9-92, the claimant underwent laminectomy and discectomy at L5-S1. This increased symptoms. Therefore, a 360-degree fusion was performed on 9-22-93 and 9-27-93. This also increased his symptoms and on 1-16-96, the claimant underwent hardware removal with left foraminal L5-S1 decompression, which also increased the claimant's symptoms. The evaluator was asked to determine whether the 1991 injury involves the cervical spine. The evaluator noted that based on the documentation reviewed, as well as the mechanism of injury including trauma to the cervical spine and consistent complaints of upper extremity neurologic compromise, he concluded that the cervical spine is included in the workers compensation claim and injury. The evaluator recommended a cervical spine MRI and electrodiagnostic testing of the upper extremities. The evaluator noted that the claimant had multiple confounding factors such as multiple motor vehicle collisions, which makes the diagnosis much more difficult.

On 2-16-09, MD., performed a Utilization Review. The evaluator noted he had reviewed the clinical information submitted and the ODG guidelines. The claimant has a narcotic contract but there is no other evidence that the prescribing physician is complying with ODG recommendations regarding the care and monitoring of a patient on chronic narcotic therapy. The tapering and discontinuation of opioid medication has been recommended by the RME. The documentation submitted and my review of the guidelines do not support the medical necessity of the requested medications.

On 2-3-09, the claimant was evaluated by Dr. Hand written notes provided. The claimant reports bad back pain and needs medication refill. He needs a letter to workers compensation for trigger points. The claimant is provided with a prescription for Alprazolam, Norco and Doxepin. The claimant reports his pain with medications is rated as 9. The claimant signed a medication contract with Dr.

On 2-23-09, DO., performed a Utilization Review. It was his opinion that the clinical information submitted fails to meet practice guidelines for the service requested. The clinical notes submitted for 2/9/09 clearly do not indicate any substantial assessment of this patient and no physical exam findings. There is no documentation of compliance with current Federal or Texas state board monitoring of a patient on chronic narcotic use. There is no assessment of aberrant behavior. There is no functional assessment noting any improvement on this medication. In fact, the claimant notes his pain to be 10/10 with medication on 2/9/09.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

Based on the documentation provided, the continued use of OxyContin is appropriate. This claimant has been on this medication for his chronic pain syndrome and failed back syndrome, at least since 2003. The claimant is status post 4 lumbar surgeries. Medical

records reflect the claimant has a controlled substance prescription agreement with his treating physician. The use of a long acting opiate medication is appropriate for a claimant with chronic pain syndrome, as there is nothing else to offer this claimant other than medical management with the use of medications. The claimant has not shown aberrant behavior with the use of this medication and is properly monitored by one provider. Therefore, certification is provided for the continued use of OxyContin 40 mg.

ODG-TWC, last update 03-17-09 Occupational Disorders of the Low Back –

Opioids use: *Chronic back pain:* Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56% (a statistic limited by poor study design). Limited information indicated that up to one-fourth of patients who receive opioids exhibit aberrant medication-taking behavior. (Martell-Annals, 2007) (Chou, 2007) There are three studies comparing Tramadol to placebo that have reported pain relief, but this increase did not necessarily improve function. (Deshpande, 2007).

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. (Webster, 2008)

- (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. (Sullivan, 2006) (Sullivan, 2005) (Wilsey, 2008) (Savage, 2008) (Ballyantyne, 2007)

5) Recommended Frequency of Visits While in the Trial Phase (first 6 months):

- (a) Every 2 weeks for the first 2 to 4 months
- (b) Then at approximate 1 ½ to 2-month intervals

Note: According to the California Medical Board Guidelines for Prescribing Controlled Substances for Pain, patients with pain who are managed with controlled substances should be seen monthly, quarterly, or semiannually as required by the standard of care. (California, 1994)

6) When to Discontinue Opioids: See Opioid hyperalgesia. Also see Weaning of Medications. Prior to discontinuing, it should be determined that the patient has not had treatment failure due to causes that can be corrected such as under-dosing or inappropriate dosing schedule. Weaning should occur under direct ongoing medical supervision as a slow taper except for the below mentioned possible indications for immediate discontinuation. The patient should not be abandoned.

- (a) If there is no overall improvement in function, unless there are extenuating circumstances
- (b) Continuing pain with the evidence of intolerable adverse effects; lack of significant benefit (persistent pain and lack of improved function despite high doses of opiates- e.g. > 120 mg/day morphine equivalents)
- (c) Decrease in functioning
- (d) Resolution of pain
- (e) If serious non-adherence is occurring
- (f) The patient requests discontinuing
- (g) Immediate discontinuation has been suggested for: evidence of illegal activity including diversion, prescription forgery, or stealing; the patient is involved in a motor vehicle accident and/or arrest related to opioids, illicit drugs and/or alcohol; intentional suicide attempt; aggressive or threatening behavior in the clinic. It is suggested that a patient be given a 30-day supply of medications (to facilitate finding other treatment) or be started on a slow weaning schedule if a decision is made by the physician to terminate prescribing of opioids/controlled substances.
- (h) Many physicians will allow one "slip" from a medication contract without immediate termination of opioids/controlled substances, with the consequences being a re-discussion of the clinic policy on controlled substances, including the consequences of repeat violations.
- (i) If there are repeated violations from the medication contract or any other evidence of abuse, addiction, or possible diversion it has been suggested that a patient show evidence of a consult with a physician that is trained in addiction to assess the ongoing situation and recommend possible detoxification. (Weaver, 2002)

(j) When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, physicians and surgeons who make a clinical decision to withhold opioid medications should document the basis for their decision.

7) 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)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE
(PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)