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Notice of Independent Review Decision

June 24, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Oxycontin Tab 80mg CR 90/30, Zolpidem Tab 10mg 30/30 , Alprazolam Tab 1mg 90/30, Hydrocodone/APAP Tab 10/325mg 240/30

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

The Reviewer is Board Certified in the area of Anesthesiology with over 6 years of experience, including Pain Management.

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who sustained an injury on xx/xx/xx. The claimant has undergone lumbar surgery and multiple conservative therapies following the initial injury. Per Peer Review dated 5/19/14, past medical history was significant for a prior injury to the low back on xx/xx/xx. An MRI scan of the lumbar spine on 9/17/98 reported minimal disc herniation at the L2-L3 level. An EMG study on 12/14/98, reported as normal but appeared to have a right-sided L5 radiculopathy per history and physical. A discogram on 6/14/99 reported concordant pain at the L2-L3 level. X-rays of the lumbar spine on 5/22/00, reported good consolidation of the fusion. A myelogram on 7/26/01, indicated a small defect at L1-L2 level.

On 4/26/02, the claimant underwent hardware removal and fusion exploration which was described as stable.

06/11/2013: Evaluation. Claimant reported that he continues to have pain in his lower back, but stated that his pain is mostly controlled with his medications. Claimant will consider spinal cord stimulation or intrathecal morphine as a long-term solution. **Pain Level:** 7. Medications not listed.

08/11/2013: Evaluation. **Pain Level:** 5. Medications not listed.

09/06/2013: Evaluation. **Pain Level:** 7. **Medications:** Norco 325mg, Cymbalta 60mg, Xanax 1mg, Flexeril 10mg.

10/03/2013: Evaluation. **Pain Level:** 6. **Medications:** Baclofen 20mg, Morphine Sulfate 30mg, Morphine Sulfate 60mg.

11/27/2013: Evaluation. **Pain Level:** 6. No medications listed.

01/21/2014: Evaluation. **Pain Level:** 6. Medications not listed.

01/02/2014: UR. Rational for Denial: The claimant is a male of undetermined age who sustained an injury on xx/xx/xx. No clinical reports were available for review. The claimant described a lifting injury and is status post lumbar fusion with hardware removal. Prior medications were noted to include Hydrocodone, Soma, and Xanax. The submitted request is for oxycontin tab 80mg CR, metoprol tar tab 50mg; lyrica cap 75mg; alprazolam tab 1mg; zolpidcm tab 10mg; hydrocodone/apap tab 10-325mg. The request for oxycontin tasb 80mg CR ; metoprol tar tab 50mg; lyrica cap 75mg; alprazolam tab 1mg; zolpidcm tab 10mg; hydrocodone/apap tab 10-325mg is not recommended as medically necessary based on the clinical documentation provided for review and current evidence based guidelines. Other than prior peer reviews from 2010 and 2012, there are no clinical reports available for review from the requesting physician to support the use of the requested medications including narcotic medications. Without further clinical documentation regarding the claimant's current clinical status, the effect and duration of the requested medications, and the indications for the requested medications; this reviewer would not recommend certification at this time.

03/18/2014: Evaluation. **Pain Level:** 6. **Current Medications:** 1. OxyContin 80mg 2. Norco 10mg 3. Xanax 1mg 4. Flexeril 10mg 5. Cymbalta 60mg 6. Lyrica 75mg 7. Naproxen 500mg 8. Metoprolol 50mg

04/25/2014: UR. Rational for Denial: The patient is a male of undetermined age injured on xx/xx/xx. The Independent Medical Evaluation dated 11/27/12 indicated the patient has undergone lumbar surgery and multiply conservative therapies following the initial injury. The document indicates the patient's medications to include Norco, Cymbalta, Zanaflex, and OxyContin. There was not recent documentation provided for review. It is unclear what the patient's current

clinical status is in regards to pain control. There was no recent evaluation regarding the efficacy of ongoing narcotic medications. Current evidence based guideline recommend that patients demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. Additionally, there was lack of recent documentation regarding compliance findings or other opioid risk assessments for dependence and diversion, as recommended by current evidence based guidelines. Without further clinical documentation to establish the patient's current condition and the effect of narcotic medications, this reviewer would not recommend Oxycontin tab 80mg CR 80mg 90/30.

05/16/2014: Evaluation. **Pain Level: 5. Medication:** 1. Norco 325mg 2. Cymbalta 60mg 3. Metoprolol Tartrate 50mg 4. OxyContin 80mg 5. Lisinopril 10mg 6. Ambien 10mg 7. Norco 325mg 8. Xanax 1mg 9. Lyrica 150mg

05/22/2014: UR. Rational for Denial: This is a claimant with chronic low back pain following an alleged work injury of xx/xx/xx. It appears the claimant has had surgery with laminectomy and fusion in 2002. There has been subsequent treatment. No recent clinicals are available for review. There is no medication contract, recent clinic notes or recent urine during screen or other compliance measures or objectification of benefit. The request is for Oxycontin tab 80mg CR 90/30/Duloxetine cap 60mg 60/30 / Alprazolam tab 1mg 90/30. Duloxetine is approved with 5 refills. Alprazolam is not approved and is not in keeping with ODG recommendations. It is a N drug. Oxycontin is approved for ONE month only. There needs to be a Non-formulary drug request as well as documentation as to its efficacy and patient's compliance with urine drug screens.

06/13/2014: Evaluation. Claimant was seen for a refill of medications. He continued to have severe pain in his lower back with radiation down the right leg to his toes. Claimant agreed to proceed with an additional epidural steroid injection on the right. He had not had one for two years. He had noted that his leg has become increasingly weak with time and that he has had several near falls. He uses a large walking stick to support himself at this time. He currently is on Oxycontin and Norco for pain relief. This appears to be controlling his pain quite well. A discussion was held concerning spinal cord stimulation. **Continue medications:** Norco 325mg, Lyrica 150mg, Cymbalta 60mg, Xanax 1mg, Oxycontin 80mg.

06/19/2014: UR. Rational for Denial: Based on the very limited clinical information available for review for this patient this reviewer would not recommend certification for any of the requested medications at this time. Other than the peer review report there are no clinical notes supporting the use of any of these medications. It is unclear what the efficacy or it is unclear what efficacy has been obtained with the continued use of these medications to support continuing prescriptions. Without updated clinical evaluations documenting functional benefits obtained with narcotics or ongoing sleep issues that would support the use of benzodiazepines or Zolpidem this reviewer would not recommend certification for the requested medications at this time.

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

The previous adverse determinations are upheld. There is limited information on which to base a recommendation for certification of these requested medications. There are no clinical notes with physical examination supporting the use of these medications. It is not clear what efficacy these medications have or whether these medications have had any efficacy at all. There is no established treatment plan, no clear indication for use other than pain and no ongoing management of these medications. Therefore, these requests for Oxycontin Tab 80mg CR 90/30, Zolpidem Tab 10mg 30/30, Alprazolam Tab 1mg 90/30, Hydrocodone/APAP Tab 10/325mg 240/30 is non-certified at this time.

CRITERIA FOR USE OF OPIOIDS

Therapeutic Trial of Opioids

1) Establish a Treatment Plan. The use of opioids should be part of a treatment plan that is tailored to the patient. Questions to ask prior to starting therapy:

- (a) Are there reasonable alternatives to treatment, and have these been tried?
- (b) Is the patient likely to improve? Examples: Was there improvement on opioid treatment in the acute and subacute phases? Were there trials of other treatment, including non-opioid medications?
- (c) Has the patient received a screen for the risk of addiction? Is there likelihood of abuse or an adverse outcome? Specific questions about current use of alcohol, illegal drugs, other prescription drugs, and over-the-counter drugs should be asked. Obtaining a history of personal and/or family substance abuse issues is important. See [Substance abuse \(tolerance, dependence, addiction\)](#). See [Opioids, screening for risk of addiction](#). (Webster, 2008) (Ballyantyne, 2007)
- (d) Ask about Red Flags indicating that opioids may not be helpful in the chronic phase: (1) Little or no relief with opioid therapy in the acute and subacute phases. (2) The patient has been given a diagnosis in one of the particular diagnostic categories that have not been shown to have good success with opioid therapy: conversion disorder; somatization disorder; pain disorder associated with psychological factors (such as anxiety or depression, or a previous history of substance abuse). Patients may misuse opioids prescribed for pain to obtain relief from depressed feelings, anxiety, insomnia, or discomfiting memories. There are better treatments for this type of pathology. (Sullivan, 2006) (Sullivan, 2005) (Wilsey, 2008) (Savage, 2008)
- (e) 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.

2) Steps to Take Before a Therapeutic Trial of Opioids:

- (a) Attempt to determine if the pain is nociceptive or neuropathic. Also attempt to determine if there are underlying contributing psychological issues. Neuropathic pain may require higher doses of opioids, and opioids are not generally recommended as a first-line therapy for some neuropathic pain.
- (b) A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics.
- (c) Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals.
- (d) Baseline pain and functional assessments should be made. Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale. See Function Measures.
- (e) Pain related assessment should include history of pain treatment and effect of pain and function.
- (f) Assess the likelihood that the patient could be weaned from opioids if there is no improvement in pain and function.
- (g) The patient should have at least one physical and psychosocial assessment by the treating doctor (and a possible second opinion by a specialist) to assess whether a trial of opioids should occur. When subjective complaints do not correlate with imaging studies and/or physical findings and/or when psychosocial issue concerns exist, a second opinion with a pain specialist and a psychological assessment should be obtained. (Sullivan, 2006) (Sullivan, 2005) (Wilsey, 2008) (Savage, 2008) (Ballyantyne, 2007)

(h) The physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian.

(i) A written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent. Patient, guardian, and caregiver attitudes about medicines may influence the patient's use of medications for relief from pain. See [Guidelines for Pain Treatment Agreement](#). This should include the consequences of non-adherence.

(j) Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs.

3) Initiating Therapy

(a) Intermittent pain: Start with a short-acting opioid trying one medication at a time.

(b) Continuous pain: extended-release opioids are recommended. Patients on this modality may require a dose of "rescue" opioids. The need for extra opioid can be a guide to determine the sustained release dose required.

(c) Only change 1 drug at a time.

(d) Prophylactic treatment of constipation should be initiated.

(e) If partial analgesia is not obtained, opioids should be discontinued.

4) 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.
 - (k) Routine long-term opioid therapy is not recommended, and ODG recommends consideration of a one-month limit on opioids for new chronic non-malignant pain patients in most cases, as there is little research to support use. The research available does not support overall general effectiveness and indicates numerous adverse effects with long-term use. The latter includes the risk of ongoing psychological dependence with difficulty weaning. See [Opioids for chronic pain](#).
- 7) When to Continue Opioids**
- (a) If the patient has returned to work
 - (b) If the patient has improved functioning and pain

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)**