

Case Number:	CM13-0014585		
Date Assigned:	10/03/2013	Date of Injury:	11/04/2002
Decision Date:	01/24/2014	UR Denial Date:	07/23/2013
Priority:	Standard	Application Received:	08/21/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiologist, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 55-year-old male who reported an injury on 11/04/2002. The mechanism of injury was noted as that the patient ran into a door while he was pulling a cart loaded with greater than 200 pounds of chicken, and the handle of the loaded cart struck him in the lower back. The patient's symptoms were noted as right side pain. Objective findings included functional range of motion and strength of the upper and lower extremities, normal sensation to light touch equally in the lower extremities, decreased range of motion in the back, tenderness to palpation along the spinous processes of the lumbar region and gluteal musculature with the right side more tender than the left side, and tight bands at the iliac on the right side. His diagnoses were listed as lumbago, postlaminectomy syndrome, and carpal tunnel syndrome. His medications were noted as Opana ER 40 mg 4 tabs twice a day and Norco 10/325 mg 1 every 6 hours for pain control.

IMR ISSUES, DECISIONS AND RATIONALES

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

Opana ER 40mg: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, On-going management, Opioids, dosing.

Decision rationale: The California MTUS Guidelines state that patients taking opioid medications need to be seen for ongoing management and review; and documentation of pain relief, functional status, appropriate medication use, and side effects needs to be included in the medical records. The pain assessment should include current pain, the least reported pain over the period since the last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long the pain relief lasts. Additionally, the guidelines require documentation of the 4 A's for ongoing monitoring, which include analgesia, activities of daily living, adverse side effects, and any aberrant drug-taking behaviors. The documentation provided for review failed to provide detailed documentation of the patient's pain relief and the 4 A's as required by the guidelines. Additionally, the patient is noted to be taking Opana ER 160 mg in the morning and 160 in the evening for a total oral morphine equivalence of 480 mg daily. Additionally, in combination with the patient's Norco, the daily morphine equivalent dosage is 520 mg a day. The California MTUS Guidelines state that dosing of opioid medications should not exceed 120 oral morphine equivalents per day; and for patients taking more than 1 opioid, the morphine equivalent dosages of the different opioids must be added together to determine the cumulative dose. As the patient's dose of opioid medication far exceeds the limit recommended by guidelines, and the detailed documentation for ongoing management was not provided in the medical records; the request is not supported. Therefore, the request is non-certified.