

Case Number:	CM13-0038979		
Date Assigned:	12/18/2013	Date of Injury:	11/01/1995
Decision Date:	02/18/2014	UR Denial Date:	09/23/2013
Priority:	Standard	Application Received:	10/01/2013

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 Family Practice and is licensed to practice in Texas. 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 60-year-old female who reported an injury on 11/01/2000 due to repetitive trauma while performing normal job duties. The patient reportedly sustained injury to her shoulder. Prior treatments included corticosteroids injections, non-steroidal anti-inflammatory medications, and physical therapy. The patient developed chronic pain that was managed with multiple medications. The patient was monitored for aberrant behavior with urine drug screens. The patient underwent an MRI of the left shoulder that revealed a full thickness tear of the supraspinatus and degenerative joint disease changes in the acromioclavicular joint. The patient underwent surgical intervention to include anterior acromioplasty and rotator cuff repair with a Mumford procedure in 02/2013. The patient was treated post surgically with a sling, physical therapy, and medications. The patient's most recent clinical examination findings included the patient's wrist pain and left shoulder pain was managed with the Norco; however, her low back pain had become unbearable. The patient described her pain at 3/10 to 8/10 with medications and 10/10 without medications. The patient's diagnoses included a lumbar sprain/strain, left rotator cuff tear, lumbar radiculopathy, chronic pain syndrome, myofascial syndrome, neuropathic pain, narcotic dependence, chronic pain related depression, and tension headaches. The patient's treatment plan included physical therapy for the left shoulder and continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Opana ER 20mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78.

Decision rationale: The requested Opana ER 20 mg #60 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has had some low back pain. However, the recent documentation does not provide a detailed physical evaluation to support subjective complaints. Therefore, the need for medication management cannot clearly be determined. Additionally, California Medical Treatment Utilization Schedule recommends the ongoing use of opioids be supported by managed side effects, monitoring for aberrant behavior, documentation of a quantitative pain assessment, and evidence of increased functional benefit. The clinical documentation submitted for review does not provide any evidence that the requested medication has provided any functional benefit for the patient's low back pain. It is noted within the documentation that the patient's shoulder pain is controlled by other medications. This medication is primarily used to control the patient's low back pain. As the clinical documentation does not provide adequate evaluation of the low back, functional benefit cannot be determined. As such, the requested Opana ER 20 mg #60 is not medically necessary or appropriate.

Opana IR 10 mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78.

Decision rationale: The requested Opana IR 10 mg #120 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has had some low back pain. However, the recent documentation does not provide a detailed physical evaluation to support subjective complaints. Therefore, the need for medication management cannot clearly be determined. Additionally, California Medical Treatment Utilization Schedule recommends the ongoing use of opioids be supported by managed side effects, monitoring for aberrant behavior, documentation of a quantitative pain assessment, and evidence of increased functional benefit. The clinical documentation submitted for review does not provide any evidence that the requested medication has provided any functional benefit for the patient's low back pain. It is noted within the documentation that the patient's shoulder pain is controlled by other medications. This medication is primarily used to control the patient's low back pain. As the clinical documentation does not provide adequate evaluation of the low back, functional benefit cannot be determined. As such, the requested Opana IR 10 mg #1200 is not medically necessary or appropriate.

1 urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, steps to avoid misuse/addiction..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

Decision rationale: The requested 1 urine drug screen is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends drug testing for patients who are suspected of using illicit drugs or require monitoring for aberrant behavior related to prescribed medications. The clinical documentation submitted for review does provide evidence that the patient has been prescribed medications that require monitoring for aberrant behavior; however, the clinical documentation submitted for review does provide evidence that the patient has been on these medications for an extended duration and has been monitored for aberrant behavior. There is no indication that the patient is at moderate to high risk for non-adherence to the prescribed medication schedule. Official Disability Guidelines recommend yearly drug screening for patients who are at low risk for aberrant behavior. As the clinical documentation submitted for review provides evidence that the patient already admitted to a urine drug screen within the last year, an additional urine drug screen would not be supported. As such, the requested urine drug screen is not medically necessary or appropriate.