

Case Number:	CM14-0105674		
Date Assigned:	07/30/2014	Date of Injury:	06/01/2000
Decision Date:	10/17/2014	UR Denial Date:	06/23/2014
Priority:	Standard	Application Received:	07/08/2014

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. The expert reviewer is Board Certified in Neuromusculoskeletal Medicine and is licensed to practice in Arizona. 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/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 48-year-old female who sustained a work related injury on 6/1/2000 as a result of an unknown mechanism of injury. Per the progress report dated March 24, 2014, the patient's current visual analog scale (VAS) score is 6-7/10 with a complaint of cervical pain that radiates through the shoulders to the bilateral arms with associated significant weakness of her upper extremities. She continues to note burning and dysesthesias in the right upper extremity. Functionally, she 'has not changed appreciably over the past few months'. On physical examination documents muscle spasm of the bilateral trapezius with multiple tender and triggers points in the upper trap muscle and tenderness of the rhomboid muscles with multiple tender and triggers points. Appreciable decreased cervical range of motion noted. Neurologically, the patient has motor weakness of bilateral upper extremities with more significant weakness on the right side. She also has sensory deficits to light touch, Thurmond and vibratory sensation in the upper extremities bilaterally. The patient remains weak in hand grip. In dispute is a decision for Opana ER tab 20mg, day supply 30, qty 60 and Hydromorphone tab 8mg, day supply 15, qty 240.

IMR ISSUES, DECISIONS AND RATIONALES

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

Opana ER Tab 20mg, Day Supply 30, QTY 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Intervention and Treatments, Page(s): 86, 93. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence:
<http://www.nyc.gov/html/doh/html/mental/MME.html>

Decision rationale: Oxymorphone (Opana), Oxymorphone Extended Release (Opana ER), no available generic: [Boxed Warnings]: Opana ER is not intended for as needed use. Patients are to avoid alcohol while on Opana ER due to increased (possibly fatal) plasma levels. Analgesic dose: (Immediate release) in opioid-naive patients the starting dose is 10- 20mg by mouth every 4 to 6 hours as needed. Patients may be started at doses of 5mg if appropriate (e.g., renal impairment). Note: It is not recommended to begin therapy at doses higher than 20mg due to adverse effects. (Extended release tablets) Opioid-naive patients should initially begin on 5mg every 12 hours around the clock. It is recommended that doses be individually titrated in increments of 5 to 10mg every 12 hours for 3 to 7 days. If the patient takes this medication as prescribed, she will ingest 120 milligram equivalents of morphine. Add this together with the Hydromorphone and the documented Methadone she is ingesting, her morphine milligram equivalent is 256 for the Hydromorphone and 60 to 90 for the Methadone, she is ingesting the equivalent of between 406 and 436mg of morphine daily. This far exceeds the 120mg daily allowed per the CA MTUS guidelines. Therefore, this request is not medically necessary.

Hydromorphon Tab 8mg, Day Supply 15, QTY 240: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Intervention and Treatments Page(s): 75, 86, 88, 91. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence:
<http://www.nyc.gov/html/doh/html/mental/MME.html>

Decision rationale: Opioid Classifications (Oxycodone): Short-acting/Long-acting opioids: Short-acting opioids: also known as "normal-release" or "immediate-release" opioids are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. Dosage should be based on the Oxycodone content and should be administered every 4 to 6 hours as needed for pain. Initially 2.5 to 5 mg by mouth every 4 to 6 hours as needed (prn) may all this required to provide analgesia. Note: Maximum daily dose is based on acetaminophen content (Maximum 4000mg/day). For more severe pain the dose (based on Oxycodone) is 10-30mg every 4 to 6 hours as needed for pain. The continued use of such medication needs periodic reassessment. This should document pain and functional improvement and compare to baseline. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Long-acting opioids: also known as "controlled-release", "extended-release", "sustained-release" or "long-acting" opioids are a highly potent form of opiate analgesic. The proposed advantage of long-acting opioids is that they stabilize medication levels, and provide around-the-clock analgesia. Long-acting opioids include: Morphine (MSContin, Oramorph SR, Kadian, Avinza), Oxycodone

(Oxycontin), Fentanyl (Duragesic Patch), Hydromorphone (Palladone). Analgesic dose: Controlled, extended and sustained release preparations should be reserved for patients with chronic pain, who are need of continuous treatment. If the patient takes this medication as prescribed, she will ingest 120 milligrams equivalents of morphine. Add this together with the Hydromorphone and the documented Methadone she is ingesting, her morphine milligram equivalent is 256 for the Hydromorphone and 60 to 90 for the Methadone, she is ingesting the equivalent of between 406 and 436mg of morphine daily. This far exceeds the 120mg daily allowed per the CA MTUS guidelines. Therefore, this request is not medically necessary.