

Case Number:	CM14-0011066		
Date Assigned:	02/21/2014	Date of Injury:	11/16/2011
Decision Date:	06/25/2014	UR Denial Date:	01/13/2014
Priority:	Standard	Application Received:	01/23/2014

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 Occupational 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 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 50-year-old female who has submitted a claim for lumbar discopathy, degenerative disk disease with radiculopathy associated with an industrial injury date of November 16, 2011. The medical records from 2013-2014 were reviewed showing the patient having severe low back pain grade 6/10 characterized as aching, burning, stabbing, throbbing, spasming, deep and shoots down her right leg. There was back stiffness with numbness on both legs. There was also radicular pain and weakness on both legs. There was worsening of condition on range of motion of the lumbar area. Physical examination of the lumbar spine showed positive for pelvic thrust pain on the right with Valsalva. There was also positive FABER maneuver, positive Gaenslen's maneuver and pain on palpation over L3-L4, L4-L5, and L5-S1 facet capsules on the right. There was rotational extension indicative of facet capsular tear on the right secondary to myofascial pain with triggering and fibrotic banding. Stork test sign was positive. MRI of the lumbosacral spine, dated December 16, 2011, indicate that there is no disk protrusion on L1-L2, L2-L3, and L3-L4. Spinal canal, and neural foramina are widely patent extending nerve roots of unremarkable appearance at L4-L5. There is a mild dorsal disk bulging and dorsal annular fissure unchanged from prior study. At L5-S1, there is a grade 1 retrolisthesis and L5-S1 with mild concentric disk bulging and end-plate spurring. The treatment to date has included medications, H-wave therapy, home exercise program, and activity modification. Autilization review dated January 13, 2014 denied the retrospective request for Opana ER 7.5mg #30 between 1/3/2014 and 1/2014 as well at the retrospective request for Exalgo 8mg #60 between 1/3/2014 and 1/3/2014. Reasons for denial were not made available.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR 1 MEDICATION: OPANA ER 7.5 MG #30 (RX GIVEN) 1/3/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 77-78.

Decision rationale: According to page 77-78 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that ongoing opioid treatment should include monitoring of analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors; these outcomes over time should affect the therapeutic decisions for continuation. In this case, the patient has been on Opana (Oxymorphone) since October 2013. A progress report dated January 3, 2014 showed a decrease in low back pain from 8 to 6 out of 10. Another progress report dated November 7, 2013 showed increased ability to participate in routine activities of daily living with its use. Guideline criteria were met for continuing opioid management. Therefore, the request for retrospective request for 1 medication: Opana ER 7.5 MG #30 (RX Given) 1/3/2014 is medically necessary.

RETROSPECTIVE REQUEST FOR 1 MEDICATION: EXALGO 8 MG # 60 (RX GIVEN) 1/3/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 77-78.

Decision rationale: According to page 77-78 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that ongoing opioid treatment should include monitoring of analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors; these outcomes over time should affect the therapeutic decisions for continuation. In this case, the patient has been on Exalgo (hydromorphone) since July 2013. It was discontinued on October 2013 when Exalgo was shifted into Opana ER. Patient reported pain relief and improved activities of daily living with Opana use. It is unclear why Exalgo was restarted in January 2014 due to lack of documentation. The medical necessity has not been established at this time. Therefore, the request for retrospective request for 1 medication: Exalgo 8 MG # 60 (RX Given) 1/3/2014 is not medically necessary.