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| Case Number: | CM14-0115681 | | |
| Date Assigned: | 08/04/2014 | Date of Injury: | 08/06/2003 |
| Decision Date: | 09/16/2014 | UR Denial Date: | 07/11/2014 |
| Priority: | Standard | Application Received: | 07/22/2014 |

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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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:

This 54 year-old individual was injured on 8/6/2003. The mechanism of injury is not listed. Progress notes on, 6/25/2014 indicates that there are ongoing complaints of low back pain that radiates in the right lower extremity. The physical examination showed lumbar spine limited range of motion with pain, bilateral straight leg raise at 80 degrees causing right-sided back pain that radiates into the right buttock and posterior thigh, disuse atrophy in the right thigh and calf compared to left side. Deep tendon reflexes are 1 + lower extremity. There is positive muscle spasm in the lumbar trunk with loss of lordotic curvature. Right hip has positive tenderness over the greater trochanter, painful range of motion and a positive Faber maneuver in the right hip. No recent diagnostic studies are available for review. Previous treatment includes medications, and conservative treatment. A request had been made for Nucynta 50 mg #45 and was not certified in the pre-authorization process on 7/11/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nucynta 50 mg #45 Between 6/25/14 and 9/8/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG) Pain (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74, 78, 93.

Decision rationale: MTUS guidelines support short-acting opiates for the short-term management of moderate to severe breakthrough pain. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic low back pain; however, there is no clinical documentation of improvement in their pain or function with the current regimen. As such, this request is not medically necessary.