

<b>Case Number:</b>	CM14-0025877		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	08/01/2007
<b>Decision Date:</b>	08/13/2014	<b>UR Denial Date:</b>	02/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/28/2014

### 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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 61-year-old man who sustained a work-related injury on August 1, 2007. Subsequently, he developed chronic low back pain radiating to both posterior thighs and knees and bilateral knee pain. Per June 10, 2014 evaluation, the patient's relevant objective findings included limited range of motion of both knees with diffuse tenderness of the left worse than right knee, visible atrophy of the right thigh compared to the left, a mild kypho-scoliotic spine curvature, paraspinal muscle rightness of the lumbar region, positive bilateral straight leg raise with lower back and radicular pain, tenderness of the lower lumbar facets, positive facet loading bilaterally, tenderness of the sacroiliac joints bilaterally, positive bilateral Ganslen's, Faber's, and compression tests bilaterally, limited spine extension, decreased range of motion with flexion of both knees, and decreased muscle mass of the right. The patient was observed to be obese and moderate discomfort with pain behavior present. He ambulated with an antalgic gait and had difficulty standing on his heels and toes with pain. According to a progress report dated on June 10, 2014, the patient underwent arthroscopic surgery with minimal relief. Subsequently, an arthroscopic surgery with debridement was performed, which gave him some more pain relief. The patient is now advice unicompartement replacement. MRI of the lumbar spine performed on January 30, 2014 indicated L4-L5 disc degeneration, L4-L5 disc disorder with annular fissure, neuroforaminal stenosis L4-L5 level bilaterally, and facet joint arthropathy moderate on right at L4-L5 and L5-S1. The patient diagnoses included chronic pain syndrome, disc displacement with radiculitis lumbar, degeneration of lumbar or lumbosacral disc, lumbosacral spondylosis without myelopathy, sacroilitis, scoliosis associated with other condition, adjustment disorder with mood anxiety and depressed mood, obesity, low testosterone level, and abdominal diastasis. The patient was treated with chiropractor manipulations, which gave him temporary relief. He was also treated conservatively with pain medications (Norco, Darvocet, Advil, BenGay, Aspirin,

Aleve, Codeine, Nucynta, Prozac, Lexapro, Oxycontin, Zoloft, and Lyrica) and physical therapy with some improvement. He had one acupuncture treatment and it seemed to slightly exacerbate his pain. The patient had the following procedures: bilateral S1 joint injection on October 21, 2013. Excellent relief for 2-3 days. Left sided medial branch block at L3, L4, and L5 on April 25, 2011, without benefit. Radifrequency procedure on the right at L3, L4, and L5 on March 24, 2011. This reduced the right-side lower back pain by 50% but did not help the left-side. 10 MBBs on the right at L3, L4, and L5 on July 30, 2010. 80% reduction of the back pain. Bilateral transforaminal epidural steroid injections on January 2010, without improvement. The provider requested authorization for Opana ER.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **PROSPECTIVE REQUEST FOR 1 PRESCRIPTION OF OPANA ER 10MG #90 WITH 2 REFILLS: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-79.

**Decision rationale:** According to MTUS guidelines, Opana is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy, (b) The lowest possible dose should be prescribed to improve pain and function, (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non adherent) drug-related behaviors. These domains have been summarized as the 4 A's (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. There is no clear evidence of objective and recent functional and pain improvement with previous use of high Opioid that justify continuing Opana. There is no clear documentation of the efficacy/safety of previous use of Opioid. There is no clear justification for the need to continue the use of Opana. There is a need to wean the patient from Opana. Therefore, based on guidelines and a review of the evidence, the request is not medically necessary.