

Case Number:	CM14-0059801		
Date Assigned:	07/09/2014	Date of Injury:	11/04/2009
Decision Date:	08/21/2014	UR Denial Date:	04/14/2014
Priority:	Standard	Application Received:	04/30/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Georgia. 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 claimant is a 50 year old male presenting with spinal cord injury and dental pain following a work related incident on 11/04/2009. On 10/15/2013, the claimant reported that his pain level has remained unchanged since the last visit. He also reported that his quality of life remained the same. The claimant's medications included Pristiq, OxyContin 40mg three times per day, Flomax 0.4mg, Oxycodone 15mg four times per day, Fludrocortisone 0.1mg and Cialis 5 mg. The x-ray of the cervical spine showed advanced cervical spondylosis and multi-level degenerative disc disease with laminectomy changes better visualized on recent CT. CT cervical spine showed status post right laminectomy from C3-5 with partial plate fixation, multi-level degenerative disc disease and spondylosis with posterior osteophytes and ossification of the posterior longitudinal ligament at the multiple levels, creating mild spinal stenosis most prominent at C6 and placing the patient at his risk for spinal cord injury with hyperextension or hyper flexion. MRI of the cervical spine showed abnormal signal intensity within the cord at the C4 level showing some minimal evidence of enhancement, raising the possibility of some postsurgical gliosis. MRI of the lumbar spine showed mild spondylosis in the lower L-Spine but no focal disc herniation nor central stenosis detected, slightly eccentric disc bulge at L3-4 resulting in asymmetric minimal right lateral recess stenosis, mild degenerative disc disease at L4-5 with disc osteophyte complex resulting in moderate right and mild to moderate left foraminal stenosis, mild bilateral facet arthropathy at L4-5 and L5-S1 with enhancement about these facets compatible with active facet arthropathy. On physical exam the claimant had antalgic gait, clonus, Babinski, decreased proprioception to motion, significant imbalance, decreased range of motion of the cervical spine, paravertebral tenderness and spasm on the thoracic spine, bruising and swelling on the bilateral elbow and wrist, positive Hoffman sign, hyperreflexia of the extremities. The claimant showed Spinal Cord Injury and Post Cervical laminectomy syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

OxyContin ER 40mg 1 PO TID #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain Page(s): 74-95. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 12 Edition (Web), 2014, Pain - Oral Corticosteroids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79.

Decision rationale: OxyContin ER 40mg 1 PO TID # 90 is not medically necessary. Per MTUS Page 79 of MTUS guidelines states that weaning of opioids are recommended if (a) there are no overall improvement in function, unless there are extenuating circumstances (b) continuing pain with evidence of intolerable adverse effects (c) decrease in functioning (d) resolution of pain (e) if serious non-adherence is occurring (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. In fact, the medical records note that the claimant was permanent and stationary. The claimant has long-term use with this medication and there was a lack of improved function with this opioid; therefore the requested medication is not medically necessary.