

Case Number:	CM14-0093941		
Date Assigned:	09/12/2014	Date of Injury:	12/08/2005
Decision Date:	11/05/2014	UR Denial Date:	06/05/2014
Priority:	Standard	Application Received:	06/20/2014

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 Pain Management 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 injured worker is a 53 year old male with a date of injury on 12/8/2005. He complained of increased pain in his cervical spine and lumbar spine. He also complained of limb pain with loss of function of affected areas, myalgias, neck pain, numbness and tingling of affected limbs, swelling, and weakness with depression. On exam, he appeared in depressed mood with moderate pain. Decreased sensations in the left over the right hand in ulnar over median areas. The injured worker underwent lower back surgery on 06/28/11 and neck surgery on 12/21/11. Allergies include Seldane and Toprol. Current medications include BuSpar, Gabitril, Lyrica, Remeron, Opana ER, carvedilol, diltiazem, fosinopril, hydrochlorothiazide (HCTZ), Pravastatin, and Prilosec. Previous treatments included physical therapy (PT) but no documentation of prior physical therapy response to the intervention. He had five epidural steroid injections which gave him only 45% improvement. As per the report of 02/05/14 medications were not effective. As per the report of 05/09/14 medications were working well and he was compliant with current medications. He was treated with Coumadin in the past for deep vein thrombosis (DVT) for which he responded well. Diagnoses include cervical post laminectomy syndrome, lumbar post laminectomy, lumbar radiculitis, chronic pain syndrome, carpal tunnel syndrome left, and ulnar nerve lesion (left). The request for oxymorphone 40mg ER #120 was modified on 09/03/14 to oxymorphone 40mg ER qty 120/30 day supply to permit weaning of total opioid dose to 120 mg MED or below.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxymorphone 40mg ER #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page 93: Oxymorphone (Opana), Oxymorphone extended release (Opana).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list Page(s): 91. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Oxymorphone (Opana®)

Decision rationale: Per the Official Disability Guidelines (ODG), oxymorphone extended release (Opana ER), is a controlled, extended and sustained release preparations that is not recommended as first line therapy. Due to issues of abuse and Black Box Food and Drug Administration (FDA) warnings, oxymorphone is recommended as second line therapy as long acting opioids. Oxymorphone products do not appear to have any clear benefit over other agents, should be reserved for injured workers with chronic pain, who are need of continuous treatment. Regarding opioids, guidelines indicate "four domains have been proposed as most relevant for ongoing monitoring of chronic pain injured workers on opioids; pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. In this case, there is no documentation of failure of first line therapy. There is little to no documentation of any significant improvement in pain level (i.e. Visual Analog Scale [VAS]) or function with prior use to demonstrate the efficacy of this medication. There is no evidence of urine drug test in order to monitor compliance. Frequent dosing of long-acting opioids is not recommended. Therefore, the medical necessity for oxymorphone ER has not been established according to guidelines and based on documentation.