

Case Number:	CM14-0197130		
Date Assigned:	12/05/2014	Date of Injury:	02/03/2003
Decision Date:	02/19/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	11/24/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Internal Medicine

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 an injured worker with a history of thoracic spine injury and paraplegia. Date of injury was 2/3/2003. The hematology consultation report dated February 26, 2014 documented a history of multiple thromboembolic episodes. Past medical history was positive for hypertension, diabetes mellitus, deep vein thrombosis, and fracture of the left femur in November of 2007. He fractured T7 in an industrial accident in 2003. Surgery on his thoracic spine two times in 2003 including the rod. He had surgery on his left forearm in 2004, and bilateral carpal tunnel repair in 1998. He had surgery for fracture of his left thumb in 1999. Surgery of his left lower leg in 1997. Physical exam was documented. He had his back brace on which completely covers his abdomen. He was examined in a wheelchair. He had a back brace on. Motor strength was no evaluated. There was no tenderness over his spine. He is paraplegic. He underwent a CT computed tomography scan of the abdomen and pelvis on July 9, 2010. There was destruction of the sacrum and portions of the lumbar spine, particularly L2- L3. There has been interval increase in the anterior displaced and lower portion of L3, relative to the upper portion of L2. He had surgery done on his lumbar spine. He had a revision from T7-S1 posterior spinal fusion with instrumentation. He had multiple fusions. There was a history of possible abscess along the lumbosacral spine down to at least the S3 area. CT computed tomography scan of his abdomen, pelvis, thoracic and lumbar spines, and sacrum were done on August 13, 2009 and total body PET positron emission tomography scan was done on August 12, 2009. The PET scan showed there was a posterior midline fluid collection extending along the vertebral column from approximately T11-T12 level through the S3 segment. There was a more solid appearing

component caudally at the sacrum that appeared to be significantly enlarged from the prior study. There is now much more soft tissue component extending posteriorly into the left gluteal region and anteriorly into the presacral space. There also appeared to be significant bony destruction throughout the lumbar spine and sacrum. Several foci of air noted in the posterior midline fluid collection, suspicious for underlying active infection and abscess. CT computed tomography scans showed a large partially calcified fluid collection posterior to the lower thoracic, lumbar, and upper sacral vertebral bodies containing a few bubbles of air, compatible with abscess. There was a marked interval increase in contiguous destructive lesion involving S1, S2, and S3 vertebral bodies with increased anterior spondylolisthesis of the S2-S3 level. The mass extended anteriorly in the pelvis to displace the rectum anteriorly and posteriorly to the left across the sacroiliac joint with destruction of the posterior left ileum. There are increasing radiolucencies surrounding the left L4 and L5 vertebral bodies screws, compatible with progressive infection. The screw that was previously in the left side of the S1 vertebral body has rotated and is now directed posteriorly into the soft tissues. There was no change in the two right-sided intraabdominal fluid collections, compatible with old hematomas or seromas, although infection could not be excluded. The progress report dated 10/27/14 documented that the patient was prescribed Duragesic and Nucynta. The patient reports needing these prescribed medications for analgesia purposes. The patient reports needing these medications for activities of daily living. The patient denies any adverse effects of these medications. The patient denies any abuse or side effects of these medications. The primary treating physician's progress report dated 11/12/14 documented subjective complaints of pain in mid to low back with numbness at times. Pain level is 2/10 with Duragesic and Nucynta. Physical examination was documented. Awake, alert, orientated male in wheelchair was noted. He has functional range of motion and strength of upper extremities, and 0 of lower extremities. He is tender to palpation of spinous processes in thoracic spinous process. Diagnoses included paraplegia and pain in thoracic spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nucynta 100mg #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, long-term assessment; Weaning of Medications. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Tapentadol (Nucynta)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines (page 89) present the strategy for maintenance for long-term users of opioids. "Do not attempt to lower the dose if it is working." Supplemental doses of breakthrough medication may be required for incidental pain, end-of dose pain, and pain that occurs with predictable situations. The standard increase in dose is 25 to 50% for mild pain and 50 to 100% for severe pain. Actual maximum safe dose will be patient-specific and dependent on current and previous opioid exposure, as well as on whether the patient is using such medications chronically. Medical records document objective evidence of pathology on physical examination

and imaging studies. Analgesia, activities of daily living, adverse side effects, and aberrant behaviors were addressed. Medical records document regular physician and nurse clinical evaluations. Medical records provide support for the prescription Nucynta. Therefore, the request for Nucynta 100mg #120 is medically necessary.