

Case Number:	CM15-0029754		
Date Assigned:	02/23/2015	Date of Injury:	05/17/2014
Decision Date:	04/03/2015	UR Denial Date:	02/05/2015
Priority:	Standard	Application Received:	02/17/2015

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: Emergency 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 injured worker is a 59 year old male, who sustained an industrial injury on 5/17/2014, while employed as a truck driver. The diagnoses have included thoracic or lumbosacral neuritis or radiculitis, unspecified. Treatment to date has included conservative measures. Currently, the injured worker complains of neck pain, with radiation to both shoulders. He also reported low back pain, with radiation to both legs, and significant left foot weakness. He also described numbness and tingling in his lower extremities, left greater than right. He was ambulatory, with an antalgic gait to the left. He had tenderness to palpation diffusely in his lumbar region and decreased range of motion. Mildly positive straight leg raise was noted bilaterally. He showed 3/5 strength with his left extensor hallucis longus and ankle dorsiflexion, and decreased Achilles reflex on the left. Physical exam of the cervical region noted tenderness to palpation at the paraspinals, left greater than right, overall restricted range of motion, and positive Spurling with extension and rotation to the left. Range of motion was restricted in his shoulders and positive impingement signs were noted. 4/5 strength was noted with external rotators of his shoulders bilaterally, as well as his deltoids. Magnetic resonance imaging of the cervical spine was referenced as showing multi-level degenerative changes C3-6 and right sided disc protrusion, causing foraminal stenosis at the C4-5 level. Magnetic resonance imaging of the lumbar spine findings were referenced as showing moderate to severe central canal stenosis at L2-3, L3-4, and L4-5, severe facet arthropathy and disc protrusion at L2-3, broad based disc protrusion at L3-4, causing moderate to severe central canal stenosis, and mild disc protrusion and facet arthropathy L4-5, causing moderate central canal stenosis and severe foraminal

stenosis. Current medication regime was not documented. On 2/05/2015, Utilization Review non-certified a prescription request for Naloxone 0.4mg/ml, noting the lack of compliance with MTUS and Official Disability Guidelines, and modified a prescription request for Oxycontin 20mg #53 to Oxycontin 20mg #32, for continued weaning, citing MTUS Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prescription of Oxycontin 20mg, #53: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82 Page(s): 78-82.

Decision rationale: The requested Oxycontin 20mg, #53, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has neck pain, with radiation to both shoulders. He also reported low back pain, with radiation to both legs, and significant left foot weakness. He also described numbness and tingling in his lower extremities, left greater than right. He was ambulatory, with an antalgic gait to the left. He had tenderness to palpation diffusely in his lumbar region and decreased range of motion. Mildly positive straight leg raise was noted bilaterally. He showed 3/5 strength with his left extensor hallucis longus and ankle dorsiflexion, and decreased Achilles reflex on the left. Physical exam of the cervical region noted tenderness to palpation at the paraspinals, left greater than right, overall restricted range of motion, and positive Spurling with extension and rotation to the left. Range of motion was restricted in his shoulders and positive impingement signs were noted. 4/5 strength was noted with external rotators of his shoulders bilaterally, as well as his deltoids. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract or urine drug screening. The criteria noted above not having been met, Oxycontin 20mg, #53 is not medically necessary.

Prescription of Naloxone 0.4mg/ml syringe #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid hyperalgesia. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Naloxone (Narcan).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Naloxone (Narcan) noted "Recommended. Naloxone (Narcan.)

Decision rationale: The requested Naloxone 0.4mg/ml syringe #1, is not medically necessary. CA MTUS is silent, and Official Disability Guidelines, Pain Chapter, Naloxone (Narcan) noted "Recommended. Naloxone (Narcan) is recommended for the complete or partial reversal of opioid depression, including respiratory depression, induced by natural and synthetic opioids." The injured worker has neck pain, with radiation to both shoulders. He also reported low back pain, with radiation to both legs, and significant left foot weakness. He also described numbness and tingling in his lower extremities, left greater than right. He was ambulatory, with an antalgic gait to the left. He had tenderness to palpation diffusely in his lumbar region and decreased range of motion. Mildly positive straight leg raise was noted bilaterally. He showed 3/5 strength with his left extensor hallucis longus and ankle dorsiflexion, and decreased Achilles reflex on the left. Physical exam of the cervical region noted tenderness to palpation at the paraspinals, left greater than right, overall restricted range of motion, and positive Spurling with extension and rotation to the left. Range of motion was restricted in his shoulders and positive impingement signs were noted. 4/5 strength was noted with external rotators of his shoulders bilaterally, as well as his deltoids. The treating physician has not documented the above-referenced criteria for the use of this medication, nor derived functional improvement from its use. The criteria noted above not having been met, Naloxone 0.4mg/ml syringe #1 is not medically necessary.