

Case Number:	CM15-0089247		
Date Assigned:	05/13/2015	Date of Injury:	05/06/2005
Decision Date:	06/22/2015	UR Denial Date:	04/13/2015
Priority:	Standard	Application Received:	05/08/2015

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: 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 injured worker is a 42 year old male patient who sustained an industrial injury on 05/06/2005. The accident is described as while working regular duty as a plumbing foreman he was lifting a 15 foot ladder when he felt acute onset of shooting pain in the back that radiated down the right leg. He put down the ladder and fell to his knees. Previous treatments to include: anti-inflammatory agents, oral steroids, physical therapy, along with electrodiagnsotic testing. In addition, he underwent a magnetic resonance imaging study, and a pain management consultation. A primary treating office visit dated 05/02/2011 reported the treating diagnoses as: chronic low back pain status post lumbar fusion at L3-S1 with posterior instrumentation; lower extremity radicular pain; depression with recent discontinuation of anti-depressant medications, and obesity. The plan of care involved: continuing with OxyContin, Ambien and pending scheduled surgery. A more recent visit dated 04/21/2015 reported the patient with current complaints of continuing to be more active; although the pain is making it difficult. He has recently begun to reduce the medication usage with the Opana IR 10mg from 75 a month to 50 a month. He states that he has been increasing activity, and walking along with losing weight. He reports the increased activity has increased his pain in the lower back, and across the right buttock, sacroiliac joint and into the right lower extremity. Objective findings showed the low back with increased muscle spasm in the paraspinal musculature and taut muscle bands extending into the thoracic region. The straight leg raise is noted with positive findings on the right at 50 degrees. There is continued decreased sensation and weakness along the L5 distribution and the S1 right dermatomal patterns. The following diagnoses are applied: low

back fusion L3 through S1; lumbar radiculopathy; chronic myofascial pain, and hypogonadism secondary to Opioid use and insomnia secondary to chronic myofascial pain. The plan of care involved: prescribing Opana 10 mg, continues with Tizanidine, Gabapentin, Ambien, undergo a lumbar epidural injection and obtain a urine screen. The patient is currently permanent and stationary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Opana IR 10mg #75: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78, 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, page 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 break-through 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. 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 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 for documentation of the clinical use of these controlled drugs. The medical records document a history of lumbar spine disc herniation, L5 radiculopathy right lower extremity, right-sided foot drop, severe disc degeneration and collapse at L4-5 and L5-S1, large disc herniation at L4-5 with severe stenosis, right leg motor and sensory deficits with foot drop, lumbar stenosis, multilevel lumbar spinal stenosis, multilevel severe degenerative disc disease, and degenerative scoliosis. MRI scan dated November 6, 2006 showed a 12 mm left paracentral disc herniation at L4-5, a 4 to 5 mm disc protrusion at L5-S1. Operative Report dated 9/12/2007 documented the performance of anterior discectomy and bilateral foraminotomy and nerve root decompression at L3-4, L4-5 and L5-S1; partial vertebrectomy with decompression of the spinal canal including L-3, L4, L5 and S1; anterior interbody fusion at L3-4, L4-5 and L5-S1; placement of allograft bone prosthesis at L3-4, L4-5 and L5-S1; placement of bone morphogenic protein at L3-4, L4-5 and L5-S1; anterior spinal instrumentation at L3-4, L4-5 and L5-S1; morselized allograft bone graft L3-4, L4-5 and L5-S1; anterior interbody fusion, L3-4, L4-5 and L5-S1. The treating physician's progress report dated April 21, 2015 documented a history of low back fusion L3 through S1 and low back complaints. Analgesia, activities of daily living, adverse side effects, and aberrant behaviors were addressed. Medical records document objective physical examination findings. Medical records document regular physician clinical evaluations and monitoring. Per FDA Prescribing Information, Opana is indicated for the relief of moderate to severe acute pain. The request for Opana is supported by the MTUS guidelines. Therefore, the request for Opana is medically necessary.