

Case Number:	CM14-0142894		
Date Assigned:	09/10/2014	Date of Injury:	10/31/2000
Decision Date:	10/14/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/03/2014

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 Physical Medicine & Rehabilitation, 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 65-year-old male who reported an injury on 10/31/2000. The mechanism of injury was not provided. On 08/12/2014 the injured worker presented bilateral neck pain, numbness of the right third, fourth and fifth digits, pain in the right arm, bilateral low back pain, pain radiating to the upper posterior right leg, and insomnia. Current medications included Opana, Oxymorphone, Lyrica, Zolpidem, and aspirin. Surgical history included a hip surgery to the right, cervical fusion from C5 to C6 and C4 to C5, neck surgery, heart valve replacement and hip surgery to the left. Upon examination of the thoracic spine there was suboccipital and occipital tenderness to the right and restricted, painful range of motion to the low back. The injured worker had shakiness with associated movements such as standing up, and his right leg tended to buckle inward while walking. The provider noted diminished sensation to the right third, fourth and fifth digits. The diagnoses were chronic pain syndrome and postlaminectomy syndrome of the cervical region. The diagnoses were cervical intervertebral discs without myelopathy, disc displacement with radiculopathy of the lumbar spine, lumbosacral spondylosis with myelopathy, and unspecified chronic ischemic heart disease. The provider recommended a prescription of Opana ER and an epidural steroid injection to the right C2-3 under fluoroscopic guidance. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prescription of Opana IR (Oxymorphone HCL) 10mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use in chronic low back pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic) Opana (Oxymorphone) for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

Decision rationale: The request for Prescription of Opana IR (Oxymorphone HCL) 10mg, #120 is not medically necessary. The California MTUS recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of evidence of an objective assessment of the injured worker's pain level, functional status, and side effects. The provider's request does not indicate the frequency of the medication in the request as submitted. As such, medical necessity has not been established.

One epidural steroid injection on the right at C2-3 under fluoroscopic guidance: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

Decision rationale: The request for One Epidural Steroid Injection on the right at C2-3 under fluoroscopic guidance is not medically necessary. According to the California MTUS Guidelines an epidural steroid injection may be recommended to facilitate progress in more active treatment plans when there is radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Additionally, documentation should show the injured worker was initially unresponsive to conservative treatment. Injections should be performed with the use of fluoroscopy for guidance, and no more than 2 root levels should be injected using transforaminal blocks. The documentation submitted for review stated that the injured worker had suboccipital and occipital tenderness present to the right. There was restricted and painful low back range of motion. More information is needed on the results of a Spurling's test, tenderness over the C2-3 facet levels, motor strength and a sensory examination. There is lack of documentation of the injured worker's failure to respond to conservative treatment to include physical medicine and medications. Additionally, documentation failed to show radiculopathy documented by physical examination findings that correlate with MRI or electrodiagnostic testing. Additionally, the documentation failed to show the injured worker would be participating in an active treatment program following the requested injection. As such, medical necessity has not been established.