

<b>Case Number:</b>	CM15-0028539		
<b>Date Assigned:</b>	03/18/2015	<b>Date of Injury:</b>	06/08/1994
<b>Decision Date:</b>	05/07/2015	<b>UR Denial Date:</b>	02/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2015

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 62-year-old female who sustained an industrial injury on 6/8/94. Past medical history was positive for hypertension, diabetes mellitus, and hypothyroidism. Past surgical history documented back surgery in 1999. The available records documented a history of failed back surgery syndrome, cervical and lumbar spondylosis, peripheral neuropathy and neurogenic bladder. Severe gastrointestinal side effects were reported secondary to chronic opioid dependence, including severe underlying gastroesophageal reflux disease, gastroparesis, and chronic constipation. The 1/27/15 treating physician report cited chronic severe low back pain radiating down the lower extremities, right worse than left, and up to the cervical spine. She ambulated with a four-wheeled walker. Average pain without medications was 10/10, and with medications 9/10. Medications were reportedly keeping her functional, and allowed for increased mobility, tolerance of activities of daily living and home exercise. Current medications included Duragesic patch, Opana ER prn pain, Lyrica, Flector, Skelaxin, and Voltaren. Multiple additional medications were prescribed by the psychiatrist, gastroenterologist, and endocrinologist. Physical exam documented antalgic gait, normal posture, marked loss in lumbar range of motion, positive bilateral straight leg raise, 1+/5 bilateral plantar flexion and dorsiflexion, hyperalgesia and allodynia right lower extremity extending to the foot, and symmetrical deep tendon reflexes. The diagnosis included lumbar postlaminectomy syndrome, lumbosacral and cervical spondylosis without myelopathy, lumbar and cervical intervertebral disc degeneration, thoracic pain, and neuritis/radiculitis. The treatment plan recommended renewal of Duragesic and Opana ER, decreased Lyrica, and authorization for intrathecal pain implant with Morphine. The 2/4/15

utilization review modified the request for Opana ER 40 mg #90 to Opana ER 40 mg #22. The rationale indicated that significant gastrointestinal complications and severe constipation were reported with opioid use, prior recommendations for weaning were noted, and an intrathecal pain pump had been certified which should eliminate the need for continued use of oral opioid medications.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**(1) Prescription of Opana ER 40mg, #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Oxymorphone (Opana), Opioids, Criteria for use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Opioids, specific drug list Page(s): 76-80, 93.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines indicate that Opana ER is not intended for as needed (prn) use. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. On-going management requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Guidelines suggest that opioids be discontinued if there is no overall improvement in function, unless there are extenuating circumstances, or when there is continuing pain with evidence of intolerable adverse effects. Guideline criteria have not been met for continued use of Opana ER. This patient presents with very limited pain relief with her current medication regime. A request has been certified for use of an intrathecal pain pump with Morphine. There is no specific objective functional improvement documented with the use of Opana ER. Significant side effects are evidenced. This medication is being prescribed on an as needed (prn) basis which is not consistent with guidelines, especially as prior discontinuation and partial certification to allow for weaning is documented in the medical records since 8/18/14. The 2/4/15 utilization review partially certified Opana ER 40 mg #22. There is no compelling reason to support the medical necessity osteoarthritis additional medication certification at this time. Therefore, this request is not medically necessary.