

Case Number:	CM13-0025249		
Date Assigned:	03/17/2014	Date of Injury:	01/06/2010
Decision Date:	05/07/2014	UR Denial Date:	09/05/2013
Priority:	Standard	Application Received:	09/16/2013

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 and Rehabilitation, has a subspecialty in Pain Medicine, 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 patient is a 46 year old male who was injured on 1/6/10 when a large piece of wood split, kicked back off a table saw, and went through the patient's nose. When he got hit with the wood, he fell back, and his neck landed on the dome of a skylight. Prior treatment history has included the following medications: Dilaudid, Duragesic, Lyrica, Fluriflex, Sintralyne, and Prilosec. The patient's surgical history is as follows: In 2010, he underwent nasal septorhinoplasty; in 2011, he had surgery to repair torn ligaments in both arms; and in 2012, he had surgery to repair the ulnar nerve. The patient also underwent a left L4 transforaminal epidural steroid injection, a right L5 transforaminal epidural steroid injection, and a left S1 transforaminal steroid injection on 6/7/13. An MRI of the left shoulder dated 12/17/10 revealed mild tendinosis without tear of the supraspinatus tendon, mild tendinosis of the intact long head biceps tendon in the intra-articular portion, intermediate signal intensity and irregular morphology of the anteroinferior labrum (likely a subacute labral tear), associated chronic cortical irregularity, and small osteophyte of the anteroinferior glenoid. An MRI of the left shoulder without contrast dated 9/20/11 revealed rotator cuff tendinosis with bursal surface fraying and focal tendinosis versus small partial tear of the distal subscapularis tendon, high grade tendinosis of the long head of the biceps tendon with severe tendinosis versus rupture of the intra-articular component, and glenohumeral joint degenerative change with labral degeneration, mostly severely involving the superior labrum. An MRI of the cervical spine dated 8/27/13 revealed nonspecific straightening of the normal cervical lordosis, query strain versus secondary to spondylotic changes (recommend clinical correlation), C3-C4 moderate and mild left neural foraminal narrowing secondary to 1-2 mm posterior disc bulge and uncovertebral osteophyte formation with bilateral exiting nerve root compromise, C4-C5 moderate left and mild right neural foraminal narrowing secondary to 1-2mm posterior disc bulge and covertebral osteophyte formation with bilateral exiting nerve root compromise, C5-C6

mild bilateral neural foraminal narrowing secondary to 1-2mm posterior disc bulge and uncovertebral osteophyte formation with bilateral exiting nerve root compromise, and C6-C7 moderate left and mild right neural foraminal narrowing secondary to 1-2mm posterior disc bulge and uncovertebral osteophyte formation with bilateral exiting nerve root compromise. An MRI of the left shoulder dated 8/29/13 revealed a complete tear of the supraspinatus tendon with 37mm tendinous retraction, status post prior rotator cuff repair, and acromioclavicular osteoarthritis. The initial treatment consultation from [REDACTED] dated 2/17/10 diagnosed the patient with naso-septal fracture and scar deformity nasal bridge. A progress note dated 5/10/10 documented that the patient is healing well. He is status post reconstructive septorhinoplasty on 4/14/10. An agreed medical exam dated 5/25/10 diagnosed the patient with facial/closed head trauma with concussion (resolved) and cervical strain with radiculitis. A consultations note by [REDACTED] dated 8/10/11 diagnosed the patient with left shoulder injury status post arthroscopic surgery. A pain management consultation dated 8/14/13 stated that the patient is in severe condition. The patient has three main pain generators: the cervical spine, the left shoulder, and myofascial syndrome manifesting as multiple painful trigger points. A PR-2 dated 9/23/13 documented the patient with complaints of neck pain, bilateral shoulder pain, and left arm pain. The pain is constant. Pain medications give him 20-40% pain relief and allow him to sleep for a few hours every night. He has improved function such that he can go out for a walk. Without the medication, the pain would be so severe that he could not function at all. Objective findings on the date of exam reveal that the patient's pain level is 8-9/10 with medications and 10/10 without medication. On average his pain is 8-9/10. He is diagnosed with cervical radiculopathy, neck pain, left shoulder sprain/strain status post surgery, left shoulder pain, cephalgia, and chronic pain syndrome. Recommendations were to check the status of authorization for a baseline functional capacity evaluation, to check the status of authorization for a one-time saliva DNA test to assess the patient's disposition, to continue current medications, to check for authorization for a cervical spine steroid injection at C5-C7 with an epidurogram as well as medical clearance, to request authorization for a urine drug screen, and to return to the clinic in two weeks for re-evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 DILAUDID 8MG, 1 EVERY 6 HOURS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-78.

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

Decision rationale: The PR-2 dated 9/23/13 documented objective findings of a pain level at 8-9/10 with medication, 10/10 and without medication. On average his pain was 8-9/10; however, the medical report does not document objective physical examination findings, only the subjective report of pain levels. Objective documentation substantiating moderate to severe pain is not established. In addition, the medical records do not establish objective evidence that this patient obtained clinically significant pain relief despite medications. Consequently, in the absence of documented pain relief, opioids should not be continued. In addition, guidelines recommend that dosing not exceed 120mg oral morphine equivalents per day (MED), and for patients taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. The total daily MED of the patient's

Duragesic patches and Dilaudid exceeds the 120mg maximum as recommended by the guidelines. Given these factors, the medical necessity of Dilaudid has not been established. The request is noncertified.

10 DURAGESIC 75MCG PATCHES, 1 EVERY 48 HOURS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-78.

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

Decision rationale: The California MTUS guidelines state that Duragesic patches are indicated for the management of persistent moderate to severe chronic pain that requires continuous, around-the-clock opioid therapy. To qualify for this medication, the pain cannot be managed by other means (e.g., NSAIDs). Duragesic should only be used in patients who are currently on opioid therapy for which tolerance has developed. The previous opioid therapy for which tolerance has occurred should be at least equivalent to fentanyl 25mcg/h. Patches are worn for a 72 hour period. The PR-2 dated 9/23/13 documented that the patient's pain level was 8-9/10 with medication, and 10/10 without medication. On average his pain was 8-9/10; however, the medical report does not document objective physical examination findings, only the subjective report of pain levels. In addition, the medical records do not establish that this patient obtained clinically significant pain relief despite medications. Furthermore, Duragesic patch is to be worn for 72 hours, not 48 hours. Consequently, in the absence of documented pain relief, and usage consistent with the guidelines, the medication should not be continued. The request is noncertified.

60 LYRICA 75MG, 1 PER DAY FOR 3 DAYS, IF NO SIDE EFFECTS, INCREASE TO 1 TWICE A DAY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

Decision rationale: According to the California MTUS guidelines, Lyrica is recommended for diabetic neuropathy and post herpetic neuralgia. It has FDA approval for both indications, and is considered first-line treatment for both. Lyrica was also approved to treat fibromyalgia. The medical records do not establish that this patient has a neuropathic pain condition. In addition, the use of this medication has not demonstrated clinically relevant reduction in pain and/or improved function. Consequently, Lyrica is not recommended. The request is noncertified.

60 SINTRALYNE, 2 AT BEDTIME: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physician's Office Resource, and the package insert.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, and FDA.gov.

Decision rationale: The Official Disability Guidelines state that there are four main categories of pharmacologic treatment for insomnia: benzodiazepines, non-benzodiazepines; melatonin & melatonin receptor agonists, and over-the-counter medications. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. The specific components of insomnia should be addressed, including sleep onset, sleep maintenance, sleep quality, and next-day functioning. Failure of sleep disturbance to resolve in a 7-10 day period may indicate a psychiatric and/or medical illness. Medication for treatment of insomnia is generally recommended only for short-term use, i.e. 7-10 days. The submitted request exceeds guideline recommendations. Furthermore, FDA.gov reveals that there is no known medication product named Sintralyn. The medical records do not provide a rationale establishing the medical necessity and appropriateness of a product that is not currently approved by the FDA for this use. Finally, subjective complaints detailing sleep issues and clinical findings/observations leading to a definitive diagnosis of insomnia has not been established. The request is noncertified.

90 PRILOSEC 20MG, 1 A DAY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: The California MTUS guidelines state that medications such as Prilosec may be indicated for patients at risk for gastrointestinal events. Risk factors include being over the age of 65; having a history of peptic ulcer, GI bleeding or perforation; concurrently using ASA, corticosteroids, and/or an anticoagulant; and/or taking high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The medical records do not establish any of these potential risk factors. As such, the request is noncertified.

90 VALIUM 10MG, 1 THREE TIMES A DAY AS NEEDED: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: Both the Official Disability Guidelines and the California MTUS guidelines state that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of psychological and physical dependence or addiction. Benzodiazepines are a major cause of overdose, particularly as they act synergistically with other drugs like opioids (mixed overdoses are often a cause of fatalities). The California MTUS states

that a more appropriate treatment for anxiety disorder is an antidepressant. The request for Valium is not supported by the evidence-based literature. The request is noncertified.

FLURIFLEX OINTMENT TRANSDERMALLY UP TO THREE TIMES A DAY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: Fluriflex is a topical compound containing Flurbiprofen and Cyclobenzaprine. According to the California MTUS guidelines, topical analgesics are often compounded as monotherapy or in combination for pain control. There is little to no research to support the use of many of these agents. The guidelines state that Cyclobenzaprine is a central muscle relaxant which is not recommended, as there is no evidence of using any other muscle relaxant as a topical product. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended, according to the MTUS. Consequently, Fluriflex ointment is not certified.

