

Case Number:	CM13-0060243		
Date Assigned:	12/30/2013	Date of Injury:	10/30/2000
Decision Date:	04/30/2014	UR Denial Date:	11/21/2013
Priority:	Standard	Application Received:	12/03/2013

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 and Pain Management, has a subspecialty in Interventional Spine 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 53 year old male with date of injury 11/30/00. The treating physician report dated 11/6/13 indicates that the patient has chronic cervical radicular pain, tinnitus, chronic left shoulder pain and bilateral hand pain. The current diagnoses are: 1.Cervical disc degeneration 2.Brachial neuritis 3.Tinnitus 4.Sleep disturbances The utilization review report dated 11/21/13 reviewed the requests for Elavil, Oxycodone, Nabumetone and Restoril were all modified and Clonidine, Reglan and shoulder MRI were all denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription of Elavil 50mg, quantity 90 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-15.

Decision rationale: The patient presents with chronic neck pain, radicular pain, left shoulder pain and sleep disturbances. The patient is status post left shoulder surgery in 2005 and 2006 and underwent a multilevel cervical fusion in July 2009. The documentation provided which

includes 282 pages including monthly treating physician pain management reports indicate that patient has been prescribed Elavil for at least the past 9 months. The MTUS guidelines support the use of tricyclic antidepressants such as Elavil (Amitriptyline) for the treatment of neuropathic pain. However the treating physician has not included any of the required information that the guidelines require (Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment.) The request is denied.

1 Prescription of Oxycodone HCL 30mg, quantity 180 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80-82.

Decision rationale: The patient presents with chronic neck pain, radicular pain, left shoulder pain and sleep disturbances. The patient is status post left shoulder surgery in 2005 and 2006 and underwent a multilevel cervical fusion in July 2009. The treating physician report dated 11/6/13 states that the patient reports extreme anxiety regarding outpatient opiate taper and detox. The treating physician states that a referral to an addiction specialist is reasonable and that there may be need for the use of Suboxone. Additionally the treating physician prescribed Oxycodone Hcl 30 Mg tablets, 2, 3x day QTY 180. In this request it is stated that 2 refills were also requested for authorization. Review of the UR report indicates that the request for Oxycodone Hcl 30 Mg tablets, 2, 3x day QTY 180 was authorized and the 2 refills were non certified. The MTUS guidelines specifically address the use of opioids and the criteria for their usage. . The treating physician reports reviewed show that month after month the patient's pain levels are an 8/10 MTUS pgs 88, 89 recommends documentation of pain and functional improvement compared to baseline. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument. MTUS further requires documentation of the four A's(analgesia, ADL's, adverse side effects, adverse behavior). The treating physician indicates that the patient needs to be seen by an addiction specialist and there are no ADL improvements documented. Without these documentations, on-going opiate use is not supported by MTUS. The request is denied.

1 Prescription of Nabumetone 750mg, quantity 60, 2 refills: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs); Anti-inflammatory medications Page(s): 67-73; 22.

Decision rationale: The patient presents with chronic neck pain, radicular pain, left shoulder pain and sleep disturbances. The patient is status post left shoulder surgery in 2005 and 2006 and underwent a multilevel cervical fusion in July 2009. The treating physician report dated

11/6/13 recommends the continue usage of Nabumetome. The MTUS guidelines state that NSAIDS are recommended for the treatment of osteoarthritis. There is no information reported that the patient is suffering from any side effects from this medication. The request is denied.

1 Prescription of Restoril 15mg, quantity 30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines, Insomnia Treatments.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The patient presents with chronic neck pain, radicular pain, left shoulder pain and sleep disturbances. The patient is status post left shoulder surgery in 2005 and 2006 and underwent a multilevel cervical fusion in July 2009. The treating physician report dated 11/6/13 recommends the continue usage of Restoril, a benzodiazepine. The MTUS guidelines are very specific that they are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. In reviewing the records provided, the patient has been taking this medication for at least the past 8 months which is outside of the guideline recommendations. The request is denied.

1 Prescription of Reglan 10mg, quantity 30 with 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA Guidelines for Reglan

Decision rationale: The patient presents with chronic neck pain, radicular pain, left shoulder pain and sleep disturbances. The patient is status post left shoulder surgery in 2005 and 2006 and underwent a multilevel cervical fusion in July 2009. The treating physician report dated 11/6/13 recommends the continue usage of Reglan. Metoclopramide (Reglan) is used for the short term treatment of GERD. Review of the treating physician reports dating back to 3/25/13 indicates the patient has been taking this medication for more than 8 months. The MTUS guidelines and ODG guidelines do not address Reglan. The FDA guidelines for Reglan clearly state that this medication is not to be used for longer than 12 weeks due to the potential side effect of tardive dyskinesia. The request is denied.

Clonidine 0.1mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines for Initiating, Transitioning and Maintaining Oral Opio.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Clonidine Page(s): 34. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines: Opioid weaning

Decision rationale: The patient presents with chronic neck pain, radicular pain, left shoulder pain and sleep disturbances. The patient is status post left shoulder surgery in 2005 and 2006 and underwent a multilevel cervical fusion in July 2009. The treating physician report dated 9/30/13 requested Clonidine 0.1mg 1-2 at night for withdrawal symptoms. This request was previously authorized on 10/15/13. The ODG guidelines recommend the usage of Clonidine to help relieve opioid withdrawal symptoms. However, ODG recommends that the Clonidine is maintained for 2-3 days after cessation of opioids and tapered over 5-10 days. Given that the treating physician is still prescribing opioids and that there is no clear plan of the weaning from these opioids and no mention in the 11/6/13 report on the effectiveness of the usage of Clonidine it does not appear that the patient requires an additional prescription for this medication. The request is denied.

1 Shoulder MRI: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, Shoulder (Acute & Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, Knee: MRI

Decision rationale: The patient presents with chronic neck pain, radicular pain, left shoulder pain and sleep disturbances. The patient is status post left shoulder surgery in 2005 and 2006 and underwent a multilevel cervical fusion in July 2009. The treating physician report dated 11/6/13 states that the patient has an average pain level of 8/10 for all of the areas of complaints. There is no information in the report to indicate that a change in diagnosis or flare up of the left shoulder has occurred. There are no objective findings or ROM findings reported. Furthermore, the file provided for review does not contain the report with the treater's request for an MRI. No rationale was provided for this review. The MTUS guidelines do not address MRI scans. The ODG guidelines for the shoulder state that repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The request is denied.