

<b>Case Number:</b>	CM14-0006969		
<b>Date Assigned:</b>	02/07/2014	<b>Date of Injury:</b>	08/27/2001
<b>Decision Date:</b>	07/02/2014	<b>UR Denial Date:</b>	12/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/18/2014

### 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 Emergency Medicine and is licensed to practice in New York. 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 57-year-old male who was injured on August 27, 2001. The patient continued to experience neck pain, back pain, and headache. Physical examination was notable for palpable twitch trigger points in the head and neck muscles and lumbar paraspinous muscles, positive right straight leg raise, normal motor strength and numbness bilateral hands. Diagnoses included cervical radiculopathy, occipital neuralgia, lumbar radiculopathy, cervical degenerative disc disease, and fibromyalgia/myositis. Treatment included medications, acupuncture, chiropractic therapy, and occipital nerve block. The patient continued to experience severe pain. Requests for authorization for Dilaudid 4mg, #180, Voltaren gel 1gm, #120 with 3 refills, Norco 10/325mg #144, Miralax 17gm packets, #1020gms with 3 refills, Soma 350mg#150, Zofran 4mg #60, Valium 10mg # 75, Opana 10mg, #180, and one (1) occipital nerve block were submitted for consideration.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DILAUDID 4MG #180:** Upheld

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

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

**Decision rationale:** Dilaudid is hydromorphone an opioid analgesic. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDS have failed. The recommended daily dose of morphine equivalents is 120 mg. In this case the patient was receiving MS Contin 60mg twice daily (120mg morphine equivalents), Norco 10/325mg up to four times daily (40mg morphine equivalents), Dilaudid 4mg up to six times daily (144mg morphine equivalents), and Opana 10mg up to six times daily (180mg morphine equivalents). This totals 484mg morphine equivalents, surpassing the recommended daily dose of morphine equivalents. The patient has been prescribed three separate opioid medications for breakthrough pain. This increases the risk of adverse effects, such as dependence and respiratory depression. In addition, the patient is not achieving analgesia. Therefore, the request is not medically necessary.

**VOLTAREN 1 % TOPICAL GEL 1 GRAM #120 GRAMS WITH 3 REFILLS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 111-112.

**Decision rationale:** Voltaren gel is the topical non-steroidal anti-inflammatory drug (NSAID) diclofenac. Topical NSAIDS have been shown to be superior to placebo in the treatment of osteoarthritis, but only in the short term and not for extended treatment. The effect appears to diminish over time. Absorption of the medication can occur and may have systemic side effects comparable to oral form. It is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, the patient is suffering from neck and back pain. The patient is not suffering from osteoarthritis in the recommended joints. Therefore, the request is not medically necessary.

**NORCO 10/325 # 144:** Upheld

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

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

**Decision rationale:** Norco is the compounded medication containing hydrocodone and acetaminophen. The Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain or function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDs have failed. The recommended daily dose of morphine equivalents is 120 mg. In this case the patient was receiving MS Contin 60mg twice daily (120mg morphine equivalents), Norco 10/32 mg up to four times daily (40mg morphine equivalents), Dilaudid 4mg up to six times daily (144mg morphine equivalents), and Opana 10mg up to six times daily (180mg morphine equivalents). This totals 484mg morphine equivalents, surpassing the recommended daily dose of morphine equivalents. The patient has been prescribed three separate opioid medications for breakthrough pain. This increases the risk of adverse effects, such as dependence and respiratory depression. In addition, the patient is not achieving analgesia. Therefore, the request is not medically necessary.

**MIRALAX 17 GRAM ORAL POWDER PACKETS 17 GRAMS # 1020 GRAMS WITH 3 REFILLS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Prophylactic Treatment of Constipation.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG Pain Opioid-induced constipation treatment.

**Decision rationale:** According to the Official Disability Guidelines opioid-induced constipation is a common adverse effect of long-term opioid use because the binding of opioids to peripheral opioid receptors in the gastrointestinal (GI) tract results in absorption of electrolytes, such as chloride, with a subsequent reduction in small intestinal fluid. Activation of enteric opioid receptors also results in abnormal GI motility. Constipation occurs commonly in patients receiving opioids and can be severe enough to cause discontinuation of therapy. If prescribing opioids has been determined to be appropriate, then the Official Disability Guidelines recommend that prophylactic treatment of constipation should be initiated. When prescribing an opioid, and especially if it will be needed for more than a few days, there should be an open discussion with the patient that this medication may be constipating, and the first steps should be identified to correct this. Simple treatments include increasing physical activity, maintaining appropriate hydration by drinking enough water, and advising the patient to follow a proper diet, rich in fiber. These can reduce the chance and severity of opioid-induced constipation and constipation in general. Miralax is polyethylene glycol, a laxative powder. It is used by dissolving it in liquid and preventing its absorption, providing a purgative effect. In this case there is no documentation that the patient is suffering from constipation, or that trial of conservative measures has failed. Therefore, the request is not medically necessary.

**SOMA 350 MG # 150:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Soma (carisoprodol).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Intervention and Guidelines Page(s): 29.

**Decision rationale:** Soma is the muscle relaxant carisoprodol. According to the Chronic Pain Medical Treatment Guidelines carisoprodol is not recommended. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Abuse has been noted for sedative and relaxant effects. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. These drugs include cocaine, tramadol, hydrocodone, benzodiazepines, and alcohol. A withdrawal syndrome has been documented that consists of insomnia, vomiting, tremors, muscle twitching, anxiety, and ataxia when abrupt discontinuation of large doses occurs. Therefore, the request is not medically necessary.

**ZOFRAN 4 MG # 60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Antiemetics (for opioid nausea).

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

**Decision rationale:** Zofran is an antiemetic. According to the Official Disability Guidelines it is not recommended for nausea and vomiting secondary to chronic opioid use. Nausea and vomiting is common with use of opioids. These side effects tend to diminish over days to weeks of continued exposure. Studies of opioid adverse effects including nausea and vomiting are limited to short-term duration (less than four weeks) and have limited application to long-term use. If nausea and vomiting remains prolonged, other etiologies of these symptoms should be considered. The medication is not recommended. Therefore, the request is not medically necessary.

**VALIUM 10 MG # 75:** Upheld

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

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

**Decision rationale:** Valium is diazepam, a benzodiazepine. According to the Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Benzodiazepines are a major cause of overdose, particularly as they act synergistically with other drugs such as opioids (mixed overdoses are often a cause of fatalities). Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. Tolerance to lethal effects does not occur and a maintenance dose may approach a lethal dose as the therapeutic index increases. In this case, the patient had been receiving Valium since at least December 2012. This is considered long-term use and is not recommended. Therefore, the request is not medically necessary.

**OPANA 10 MG # 180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Oxymorphone (Opana).

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

**Decision rationale:** Opana is the opioid analgesic oxymorphone. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain or function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDS have failed. The recommended daily dose of morphine equivalents is 120mg. In this case the patient was receiving MS Contin 60mg twice daily (120mg morphine equivalents), Norco 10/325mg up to four times daily (40mg morphine equivalents), Dilaudid 4mg up to six times daily (144mg morphine equivalents), and Opana 10mg up to six times daily (180mg morphine equivalents). This totals 484mg morphine equivalents, surpassing the recommended daily dose of morphine equivalents. The patient has been prescribed three separate opioid medications for breakthrough pain. This increases the risk of adverse effects, such as dependence and respiratory depression. In addition, the patient is not achieving analgesia. Therefore, the request is not medically necessary.

**1 OCCIPITAL NERVE BLOCK BILATERALLY UNDER FLUOROSCOPY AND ANESTHESIA:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic), Greater Optic Nerve Block.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Greater occipital nerve block, diagnostic; Greater occipital nerve block, therapeutic; and the International Association for the Study of Pain and World Cervicogenic Headache Society.

**Decision rationale:** The California MTUS Guidelines do not address this issue. Greater occipital nerve blocks (GONB) have been recommended by several organizations for the diagnosis of both occipital neuralgia and cervicogenic headaches. It has been noted that both the International Association for the Study of Pain and World Cervicogenic Headache Society focused on relief of pain by analgesic injection into cervical structures, but there was little to no consensus as to what injection technique should be utilized and lack of convincing clinical trials to aid in this diagnostic methodology. Difficulty arises in that occipital nerve blocks are non-specific. This may result in misidentification of the occipital nerve as the pain generator. In addition, there is no research evaluating the block as a diagnostic tool under controlled conditions. An additional problem is that patients with both tension headaches and migraine headaches respond to GONB. There is little evidence that the block provides sustained relief, and if employed, is best used with concomitant therapy modulations. Current reports of success are limited to small, non-controlled case series. Although short-term improvement has been noted in 50-90% of patients, many studies only report immediate post-injection results with no follow-up period. In this case, the patient had received an occipital nerve block and achieved pain relief for only 4 days. Lack of past success is an indicator that future therapy is unlikely to be effective. Therefore, the request is not medically necessary.