

Case Number:	CM14-0164091		
Date Assigned:	10/08/2014	Date of Injury:	07/23/2003
Decision Date:	11/10/2014	UR Denial Date:	09/13/2014
Priority:	Standard	Application Received:	10/06/2014

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 Occupational 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 claimant was injured on 07/23/03. Medrox ointment, Percocet, orphenadrine, and Butrans patch are under review. The claimant has had chronic neck, back, shoulder, and ankle pain but her shoulder remains the primary problem. She had an Agreed Medical Evaluation on 03/04/08. She had pain in the right shoulder and elbow, neck pain radiating to the arms to her fingers with numbness and tingling, pain in the upper back and low back radiating to the lower extremities. She had had extensive treatment. Diagnoses included residuals of chronic cervical strain with spondylosis and degenerative disc disease and probable chronic strain of the right shoulder with tendinitis. She was status post arthroscopic decompression of the right shoulder in October 2006 and manipulation under anesthesia in May 2007. She also underwent revision ulnar nerve exploration and decompression and medial epicondylectomy of the right elbow in March 2006. She had some psychiatric diagnoses. There was a high level of his subjective complaints. An MRI of the right shoulder dated 05/30/13 revealed mild tendinosis of the anterior distal infraspinatus tendon with no rotator cuff tear. There was mild or suggestion of mild bursitis. There was mildly widened before meals joint. On 07/09/13, an electrodiagnostic study revealed right ulnar neuropathy and no acute cervical radiculopathy. She reported ongoing pain on 01/15/14. She had no subcutaneous fat about the acromion and distal clavicle which looked very odd. She had a Tinel's at the tip of the acromion and it was allodynic. Her shoulder was very stiff. She was diagnosed with a postoperative neuroma that was complicated by severe soft tissue and fat atrophy of the top of her shoulder. Surgery was under consideration. On 01/28/14, she was diagnosed with possible suprascapular nerve damage. She was referred to another specialist. MRI of the cervical spine on 03/15/11 showed straightening of the normal lordotic curvature that was usually secondary to muscular spasm and there was mild narrowing of the right neural foramen at C3-4 and a mild degree of central stenosis at C5-6 where there was

marked narrowing of both neuroforamina. There is a posterior disc protrusion at C6-7 with marked narrowing of the neuroforamen. She had an MRI of the right shoulder on 05/03/11 that showed likely grade 2 strain in the lateral deltoid with a hematoma or an abscess. There was a partial-thickness intrasubstance tear of the supraspinatus tendon and anterior infraspinatus tendon and diffuse degenerative change. On 03/04/14, she was waiting to see the specialist. The tip of her shoulder was exquisitely tender and she had difficulty wearing clothes. She had significant shoulder drooping. Butrans patches were ordered. On 03/28/14, she saw the specialist and was status post 2 shoulder operations for labral tear. Her pain was diffuse throughout the entire shoulder as well as the scapular area and radiated to the middle 3 fingers and had not improved at all. She was taking Xanax and narcotics. She was diagnosed with CRPS. There were no surgical options. Gabapentin was recommended for pain management. On 04/01/14, her provider indicated that the specialist could not do anything for her. Her shoulder was sensitive and she had numbness and tingling in the right upper extremity. She was to follow-up with the shoulder specialist. On 04/29/14, there was no improvement and she had developed increased back pain. Her findings were generally the same. She was prescribed Medrol, Percocet, Celebrex, orphenadrine, and Butrans patch. On 06/10/14, she was unchanged. She was awaiting authorization to see the shoulder specialist and remained on Medrox, Percocet, Celebrex, orphenadrine, and Butrans patch. On 07/08/14, she was still waiting to see the shoulder specialist. The Butrans dose was increased. On 07/29/14, she continued the medication. On 08/26/14, there was no significant improvement since the last exam.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medrox ointment, 120g with 2 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 Topical Analgesics Page(s): 143.

Decision rationale: The history and documentation do not objectively support the request for Medrox 120 g with 2 refills. The California Medical Treatment Utilization (MTUS) state "topical agents may be recommended as an option [but are] largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004)." There is no evidence of failure of all other first line drugs. The claimant received refills of several other medications for pain with no documentation of intolerance or lack of effectiveness. The medical necessity of this request for the topical agent Medrox 120 g with 2 refills has not been clearly demonstrated.

Percocet 10/325mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Specific Drug List, Oxycodone/Acetaminophen. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines , Opioids for Chronic Pain and the 4 A's, Page(s): 110.

Decision rationale: The history and documentation do not objectively support the request for the opioid, Percocet 10/325, frequency and quantity, unknown. The California Medical Treatment Utilization (MTUS) outlines several components of initiating and continuing opioid treatment and states "a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." In these records, there is no documentation of trials and subsequent failure of or intolerance to first-line drugs such as acetaminophen or nonsteroidal anti-inflammatory drugs. California MTUS further explains, "pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts." There is no indication that periodic monitoring of the claimant's pattern of use and response to this medication, including assessment of pain relief and functional benefit, has been or will be done. There is no evidence that she has been involved in an ongoing rehab program to help maintain any benefits she receives from treatment measures. Additionally, the 4A's "analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors" should be followed and documented per the guidelines. The claimant's pattern of use of Percocet is unclear. It is not clear when she takes it and specifically what benefit she receives after a dose and how long the reported pain relief lasts. There is no evidence that a pain diary has been recommended and is being kept by the claimant and reviewed by the prescriber. As such, the medical necessity of the ongoing use of Percocet 10/325 mg has not been clearly demonstrated.

Orphenadrine ER 100mg #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxers Page(s): 97.

Decision rationale: The history and documentation do not objectively support the request for orphenadrine ER 100 mg #60 with 2 refills. The MTUS Chronic Pain Medical Treatment guidelines state "Muscle relaxants (for pain) - recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some

medications in this class may lead to dependence. (Homik, 2004) Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen. (Chou, 2004)" Additionally, MTUS and ODG state "relief of pain with the use of medications is generally temporary and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication to be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medication should show effects within 1 to 3 days, ... A record of pain and function with the medication should be recorded. (Mens 2005)" The medical documentation provided does not establish the need for long-term/chronic usage of orphenadrine, which MTUS guidelines advise against. Additionally, the medical records provided do not provide objective findings of acute spasms or a diagnosis of acute spasm. In this case, the claimant's pattern of use of medications, including other first-line drugs such as acetaminophen and anti-inflammatories and the response to them, including relief of symptoms and documentation of functional improvement, have not been described. The recommended dosage is not stated. As such, this request for orphenadrine ER 100 mg #60 with 2 refills is not medically necessary.

Butrans 20mcg/hr patches: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines buprenorphine Page(s): 57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Formulary: BuTrans

Decision rationale: The history and documentation do not objectively support the request for Butrans patch 20 mcg/hr, frequency and quantity unknown. The MTUS p. 57 state "buprenorphine may be recommended for treatment of opiate addiction. Also recommended as an option for chronic pain, especially after detoxification in patients who have a history of opiate addiction." The ODG formulary states buprenorphine may be "recommended as an option for treatment of chronic pain (consensus based) in selected patients (not first-line for all patients). Suggested populations: (1) Patients with a hyperalgesic component to pain; (2) Patients with centrally mediated pain; (3) Patients with neuropathic pain; (4) Patients at high-risk of non-adherence with standard opioid maintenance; (5) For analgesia in patients who have previously been detoxified from other high-dose opioids. Use for pain with formulations other than Butrans is off-label. Due to complexity of induction and treatment the drug should be reserved for use by clinicians with experience." There is no clear evidence that the claimant has tried and failed all other reasonable first line drugs and the benefit to her of the use of this medication is unclear. There is no evidence that the ODG criteria have been met, in particular, that the claimant has a hyperalgesic component to her pain, centrally mediated pain, neuropathic pain (she describes and

has findings of soft tissue/muscular tenderness but no focal neurologic deficits) or is at high risk of non-adherence with standard opioid maintenance which she has used in the past. There is no history of detoxification. She has been prescribed oral medications but the results are not clear, including side effects and ineffectiveness. The medical necessity of this request for Butrans patch 20 mcg/hr has not been demonstrated.