

Case Number:	CM14-0051047		
Date Assigned:	07/07/2014	Date of Injury:	11/11/2005
Decision Date:	08/29/2014	UR Denial Date:	03/27/2014
Priority:	Standard	Application Received:	04/18/2014

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 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 patient is a 55-year-old female who has submitted a claim for adhesive capsulitis of the shoulder associated with an industrial injury date of November 11, 2005. Medical records from 2013 to 2014 were reviewed. The patient was being seen for chronic lumbar spine and right shoulder pain associated with stiffness and weakness. Pain level was 3-4/10 with use of prescription narcotics, and 10/10 without medications. She is in a wheelchair and reports not being able to walk on her own. Physical examination showed limitation of motion of the cervical spine; tenderness over the bilateral cervical paravertebral muscles; tight muscle band and trigger point with a twitch response along with radiating pain over the right cervical paravertebral muscles; C5-C6 spinous process tenderness; and neck pain radiating to the upper extremity with mottling and temperature changes in the hand upon Spurling's maneuver on the right. Examination of the right shoulder showed limitation of motion; diffuse tenderness over the shoulder girdle; marked pain of the GH joint; periscapular muscle trigger points; and positive Hawkin's and Neer tests. Neurologic examination demonstrated hand tremors and hyperreflexic upper and lower limbs. The diagnoses were brachial neuritis or radiculitis; adhesive capsulitis of shoulder; Chronic Fatigue Syndrome; and lumbar or lumbosacral disc degeneration. Current medications include Duragesic 50mcg/hr patch, Valium 10mg, Zofran 8mg, and Duragesic 12 mcg/hr patch. Treatment plan includes a request for medication refills. Treatment to date has included Cymbalta, Lyrica, anti-inflammatories, neuropathic agents, stellate blocks, epidural catheter, physical therapy, and home exercise program. Utilization review from March 27, 2014 denied the request for Valium 10mg #60 with 1 refill because long term use is not recommended. Long-term efficacy is unproven, and there is risk of dependence. Evidence of measurable subjective and/or functional benefit as a result of medication, and documentation of medical necessity were also lacking. The request for Duragesic 50mcg/hr patch #15 and Duragesic

12mcg/hr patch #25 were also denied because submitted report lacks actual results of current urine drug screen. Request for Zofran 8mg #120 with refill was denied as well because guidelines do not recommend this medication for nausea secondary to chronic opioid use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Valium 10mg #60 with 1 refill: Upheld

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

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

Decision rationale: Page 24 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that benzodiazepines 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. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. Likewise, tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. In this case, Valium intake was noted as far back as March 2013. This was taken for anxiety and severe muscle spasms. However, there was no objective evidence of failure of other muscle relaxants or antidepressants that would necessitate use of Valium. Moreover, there was no objective evidence of overall pain improvement and functional gains directly attributed to its use. The guideline does not support long term use because tolerance develops rapidly, and there is risk for dependence. The medical necessity has not been established. There was no compelling rationale concerning the need for variance from the guideline. Therefore, the request for Valium 10mg #60 with 1 refill is not medically necessary.

Duragesic 50mcg/hr patch #15: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system); Fentanyl transdermal Page(s): 44, 93.

Decision rationale: Page 44 and 93 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that Duragesic (fentanyl transdermal system) is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. In this case, Duragesic patch was used as far back as March 2013. No side effects were reported, and documents show evidence of pain improvement and functional gains with use. A urine drug screen obtained on April 10, 2014 was consistent with prescription medications. The medical necessity has been established. Therefore, the request for Duragesic 50mcg/hr patch #15 is medically necessary.

Duragesic 12mcg/hr patch #25: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system); Fentanyl transdermal Page(s): 44, 93.

Decision rationale: Page 44 and 93 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that Duragesic (fentanyl transdermal system) is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. In this case, Duragesic patch was used as far back as March 2013. No side effects were reported, and documents show evidence of pain improvement and functional gains with use. A urine drug screen obtained on April 10, 2014 was consistent with prescription medications. The medical necessity has been established. Therefore, the request for Duragesic 12mcg/hr patch #25 is medically necessary.

Zofran 8mg, #120 with 1 refill: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter: Antiemetics (for opioid nausea) Other Medical Treatment Guideline or Medical Evidence: FDA (Ondansetron).

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. ODG does not recommend antiemetics for nausea and vomiting secondary to chronic opioid use. The FDA states that Ondansetron is indicated for prevention of nausea and vomiting caused by cancer chemotherapy, radiation therapy and surgery. In this case, the patient complains of persistent nausea associated with opioid use. The guideline does not recommend antiemetics for opioid-induced nausea. There was no compelling rationale concerning the need for variance from the guideline. The medical necessity has not been established. Therefore, the request for Zofran 8mg, #120 with 1 refill is not medically necessary.