

Case Number:	CM14-0115791		
Date Assigned:	08/04/2014	Date of Injury:	05/05/2010
Decision Date:	01/02/2015	UR Denial Date:	07/22/2014
Priority:	Standard	Application Received:	07/23/2014

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 Anesthesiology and is licensed to practice in Tennessee, North Carolina, and Georgia. 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 injured worker is a 55-year-old female who reported an injury on 05/05/2010 due to an unknown mechanism. Past treatments included physical therapy, home exercise program, and the implantation of a spinal cord stimulator in 07/2013. The injured worker reported that she had no significant change in her symptoms other than the fact that she was able to sleep for 3 hours at a time at night. The injured worker had a physical examination on 06/26/2014 that revealed complaints of neck pain. It was reported that the injured worker's activity level has decreased. Medications are Relpax 40 mg 1 tablet for onset of headache, Zanaflex 4 mg 1 daily, Zofran 4 mg 1 daily as needed, oxycodone 15 mg 1 tablet twice a day as needed, Duragesic 50 mcg patch 1 patch every 3 days. The injured worker reported no side effects from the medications. It was also noted that the injured worker had a cervical epidural steroid injection 02/25/2014. The injured worker had arthroscopic subacromial decompression; release of coracoacromial ligament and debridement of partial bursal side rotator cuff tear, right shoulder 06/14/2011. The injured worker also had anterior cervical discectomy with fusion and plate fixation at the C5-6 on 11/01/2011. Examination of the cervical spine revealed range of motion was restricted with lateral rotation to the right limited to 74 degrees with pain and normal flexion, extension, right lateral bending, left lateral bending, and lateral rotation to the left. Hoffmann's was negative, and there was a positive Tinel's over the right occipital nerve. Neurological examination revealed elbow flexors were 4/5 on the right, and elbow extensors were 4/5 on the right. Sensory examination with light touch was decreased over the index finger, middle finger, ring finger on the right side, and dysesthesias were present over the thumb and index finger. Upper and lower extremities responded normally to reflex examination. It was also noted that the injured worker continues to use the H-wave machine 1 to 2 times per day and reports 50% pain relief for up to 2 hours. It was reported that the provider was attempting to slowly wean the injured worker from

her medications. It was also reported that the injured worker does not exhibit any aberrant behavior. Urine drug screening has been consistent and there are no red flags. The injured worker has functional benefit and improved quality of life. The injured worker has a pain contract which is discussed regularly. The injured worker submits to periodic random urine drug screens. The request for authorization was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine HCL 4mg #20, 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Pain Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The decision for tizanidine HCl 4mg #20, 3 refills is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time and there is a lack of documentation of objective improvement. Therefore, continued use of this medication would not be supported. Therefore, this request is not medically necessary.

Oxycodone 15mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 78.

Decision rationale: The decision for oxycodone 15mg #60 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend providing ongoing education on both the benefits and limitations of opioid treatment. The guidelines recommend the lowest possible dose should be prescribed to improve pain and function. There should also be documentation of ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The pain assessment should include current pain, the least reported pain over the period since the last assessment, average pain, intensity of pain after taking opioid, how long it takes for pain relief and how long the pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function or improved quality of life. The provided medical documentation lacked evidence of the injured worker's failure to respond to nonopioid analgesics. The documentation

lacks evidence of the efficacy of the medication, a complete and accurate pain assessment. The clinical documentation submitted for review has records from 2013 where it was reported the injured worker was to be weaned from these opioid medications. Furthermore, the request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.

Duragesic 50mcg/hr patch #10: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 78.

Decision rationale: The decision for duragesic 50mcg/hr patch #10 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend providing ongoing education on both the benefits and limitations of opioid treatment. The guidelines recommend the lowest possible dose should be prescribed to improve pain and function. There should also be documentation of ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The pain assessment should include current pain, the least reported pain over the period since the last assessment, average pain, intensity of pain after taking opioid, how long it takes for pain relief and how long the pain relief lasts. Satisfactory response to treatment may be indicated by the injured worker's decreased pain, increased level of function or improved quality of life. The provided medical documentation lacked evidence of the injured worker's failure to respond to nonopioid analgesics. The documentation lacks evidence of the efficacy of the medication, a complete and accurate pain assessment. The clinical documentation submitted for review has records from 2013 where it was reported the injured worker was to be weaned from these opioid medications. Furthermore, the request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.

Zofran 4mg #10, 3 refills: 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, Antiemetics (for opioid nausea)

Decision rationale: The request for zofran 4mg #10, 3 refills is not medically necessary. The California MTUS/ACOEM Guidelines do not address this medication. The Official Disability Guidelines were referenced. The Official Disability Guidelines do not recommend antiemetics for nausea and vomiting secondary to chronic opioid use. Nausea and vomiting is common with the use of opioids. These side effects tend to diminish over days to weeks of continued exposure. If nausea and vomiting remains prolonged, other etiologies of the symptoms should be

evaluated for. Differential diagnoses include gastroparesis (primarily due to diabetes). Current research for treatment of nausea and vomiting as related to opioid use primarily addresses the use of antiemetics in patients with cancer pain or those utilizing opioids for acute/postoperative therapy. The medical guidelines do not support the use of antiemetics for patients that have chronic opioid use. Furthermore, the request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.

Relpax 40mg #9: 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 Head 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) Head, Migraine pharmaceutical treatment

Decision rationale: The decision for Relpax 40mg #9 is not medically necessary. The California MTUS/ACOEM Guidelines do not address this request directly. Official Disability Guidelines were referenced. The guidelines recommend triptans for migraine sufferers. At marketed doses, all oral tryptans (e.g. sumatriptan, brand name Imitrex) are effective and well tolerated. Differences among them are generally relatively small, but clinically relevant for individual patients. A poor response to 1 triptan does not predict a poor response to other agents in that class. The efficacy of the medication Relpax was not indicated in the clinical documentation. Furthermore, the request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.