

Case Number:	CM14-0195544		
Date Assigned:	12/03/2014	Date of Injury:	05/24/2002
Decision Date:	03/18/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/21/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 52-year-old female with an injury date of 05/24/02. Based on 10/17/14 progress report, the patient complains of pain in the right shoulder. Physical examination of the cervical spine reveals tenderness to palpation and hypertonicity of the bilateral paravertebral muscles along with restricted range of motion due to the pain. Range of motion in the bilateral shoulders is also restricted. There is tenderness to palpation in the right subdeltoid bursa and trapezius. The Hawkin's test is positive on the right. In progress report dated 09/19/14, the patient rates her pain with medications as 2/10 and without medications at 7/10. List of medications, as per progress report dated 10/17/14, includes Lidoderm patches, Avinza, Zanaflex, Roxicodone, Soma, Nortriptyline HCL, Clonazepam, Hydrochlorothiazide, Relpax, Flonase, Ambien, Amlodipinepine Besylate, Ondansetron, and Prozac. The patient has received 6 sessions of physical therapy for the right shoulder to strengthen, stabilize, and teach home exercises. The patient's work status has been determined as permanent and stationary. She has been advised to avoid certain activities, as per progress report dated 10/17/14. MRI of the Cervical Spine, 11/07/11, as per progress report dated 08/22/14: Degenerative disc disease and spondylosis between C2 and C4 causing bilateral narrowing of the C5-C6 neural foramina, worse on the right. MRI of the Left Shoulder, 11/02/11, as per progress report dated 08/22/14: Minimal amount of signal in the subacromial subdeltoid bursa, possible bursitis; Small glenohumeral effusion; Prominent soft tissue structure in the region of the middle glenohumeral ligamentDiagnosis, 10/17/14: Shoulder pain. The treater is requesting for (a) AVINZA 30 mg # 30 (b) AVINZA 120 mg # 30 (c) ROXICODONE 15 mg # 180 (d) ZANAFLEX 4 mg # 60. The

utilization review determination being challenged is dated 10/30/14. The opiates were denied due to lack of objective functional improvement, and Zanaflex for lack of short-term use. Treatment reports were provided from 10/04/13 - 11/14/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Avinza 30mg #30: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 88, 89, 76-78.

Decision rationale: The patient presents with right shoulder pain along with restricted range of motion, as per progress report dated 10/17/14. The request is for AVINZA 30 mg # 30. The pain is rated at 2/10 with medications and 7/10 without medications, as per progress report dated 09/19/14. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. A review of the available progress reports indicates that Avinza 60 mg and 120 mg were prescribed to the patient consistently from at least 10/04/13. The Avinza 60 mg was changed to Avinza 30 mg from 10/17/14. The treater states that the patient cannot use NSAID for pain relief secondary to a kidney disease, and a decrease in Avinza has led to an increase in pain. However, the treater plans to retain the current dosage. Progress report dated 09/19/14 reflects that medications help reduce pain from 7/10 to 2/10. In progress report dated 10/17/14, the treater states that "With medications the patient can perform household tasks including cooking, cleaning, self-care for 30 to 45 minutes or greater at a time." The treater also further reports that "Without medications the patient cannot perform these tasks or is limited to 10 minutes or less." Urine drug screen and CURES report are consistent with opioid use, as per the same report. Additionally, the treater states that the patient is not experiencing any side effects or aberrant behavior. Since the four A's, including analgesia, specific ADL's, adverse reactions, and aberrant behavior, are adequately addressed, this medication IS medically necessary.

Avinza 120mg #30: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 88, 89, 76-78.

Decision rationale: The patient presents with right shoulder pain along with restricted range of motion, as per progress report dated 10/17/14. The request is for AVINZA 120 mg # 30. The pain is rated at 2/10 with medications and 7/10 without medications, as per progress report dated 09/19/14. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. A review of the available progress reports indicates that Avinza 120 mg has been prescribed consistently from at least 10/04/13. The treater states that the patient cannot use NSAID for pain relief secondary to a kidney disease, and a decrease in Avinza from 180 mg to 120 mg has led to an increase in pain. However, the treater plans to retain the current dosage. Progress report dated 09/19/14 reflects that medications help reduce pain from 7/10 to 2/10. In progress report dated 10/17/14, the treater states that "With medications the patient can perform household tasks including cooking, cleaning, self-care for 30 to 45 minutes or greater at a time." The treater also further reports that "Without medications the patient cannot perform these tasks or is limited to 10 minutes or less." Urine drug screen and CURES report are consistent with opioid use, as per the same report. Additionally, the treater states that the patient is not experiencing any side effects or aberrant behavior. Since the four A's, including analgesia, specific ADL's, adverse reactions, and aberrant behavior, are adequately addressed, this medication IS medically necessary.

Roxicodone 15mg #180: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 88, 89, 76-78.

Decision rationale: The patient presents with right shoulder pain along with restricted range of motion, as per progress report dated 10/17/14. The request is for ROXICODONE 15 mg # 180. The pain is rated at 2/10 with medications and 7/10 without medications, as per progress report dated 09/19/14. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. A review of the available progress reports indicates that ROXICODONE 15 mg # 180 has been prescribed consistently from at least 10/04/13. The treater states that the dose has been reduced from 8/day to 6/day. Progress report dated 10/17/14 reflects that Roxicodone helps reduce pain from 7/10 to 2/10. The medication is helping the patient use her arms for eating and for ADLs such as grocery shopping. The treater states that "With medications the patient can perform household tasks including cooking, cleaning, self-care for 30to 45 minutes or greater at a time." The treater also further reports that "Without medications the patient cannot perform these tasks or is limited to 10 minutes or less."

Urine drug screen and CURES report are consistent with opioid use, as per the same report. Additionally, the treater states that the patient is not experiencing any side effects or aberrant behavior. Since the four A's, including analgesia, specific ADL's, adverse reactions, and aberrant behavior, are adequately addressed, this medication IS medically necessary.

Zanaflex 4mg #60: Overturned

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 relaxants Page(s): 63-66.

Decision rationale: The patient presents with right shoulder pain along with restricted range of motion, as per progress report dated 10/17/14. The request is for ZANAFLEX 4 mg # 60. The pain is rated at 2/10 with medications and 7/10 without medications, as per progress report dated 09/19/14. MTUS Guidelines pages 63 through 66 state "recommended non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic low back pain." They also state, "This medication has been reported in case studies to be abused for euphoria and to have mood elevating effects." In this case, the patient has consistently received Zanaflex since at least 10/04/13. As per progress report dated 10/17/14, Zanaflex and Soma are the only two muscle relaxants approved for the patient due to a kidney disease. The treater states that "She is able to take Zanaflex in the middle of the night for stiffness and discomfort. Without the medication, her spouse would need to lift her from the bed in the am due to increased stiffness." Although most muscle relaxants are approved for short-term use, Zanaflex can be used for extended period of time. Given the patient's severe symptoms and impact of Zanaflex on pain and function, this request IS medically necessary.