

Case Number:	CM14-0207371		
Date Assigned:	12/19/2014	Date of Injury:	12/23/2008
Decision Date:	02/11/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/11/2014

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 Physical Medicine Rehabilitation, has a subspecialty in Interventional Spine 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 59 year old female with an injury date on 12/23/2008. Based on the 10/15/2014 progress report provided by the treating physician, the diagnoses are: 1. Cervicalgia 2. Pain in joint, shoulder region. According to this report, the patient complains of constant "pain in the BL shoulder, right upper extremities." The pain is "aching, sharp, shooting, stabbing and throbbing. The pain radiates to the neck, bilaterally into the head and bilateral lower extremity. On average about 7/10, and right now is 6/10." The pain is made worse by increased activity and standing a long time and better by applying cold/heat, injections, taking medications and resting. The patient also complains of "difficulty staying asleep due to pain, feeling blue all the time." The patient's objective findings were not provided in this report. Treatment to date includes kidney stones removal, Shoulder surgery, and Gastric bypass. The treatment plan is to request for in-patient detoxification, continues current medications, and discontinue Suboxone Robaxin, and Clonidine. The patient's work status is "currently not working." The 09/18/2014 report indicate patient average pain "about 7/10, and right now it is 10/10." The 08/05/2014 report indicates patient average pain "about 5/10, and right now it is 6/10." The utilization review denied the request for (1) Duragesic #15, (2) Lidoderm 5% #60, (3) Savella #60, (4) Rozerem #30 with 2 refills, and (5) Edluar 10mg #10 on 11/21/2014 based on the MTUS/ODG guidelines. The requesting physician provided treatment reports from 02/12/2014 to 10/15/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Duragesic 50mcg/hr #15: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (Fentanyl transdermal system) Page(s): 44.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic and Medications for chronic pain Page(s): 44, 88-89.

Decision rationale: According to the 10/15/2014 report, this patient presents with constant pain in the BL shoulder, right upper extremities that is "aching, sharp, shooting, stabbing and throbbing and "difficulty staying asleep due to pain." The current request is for Duragesic 50mcg/hr #15. The MTUS Guidelines page 44 states Duragesic (fentanyl transdermal system) is not recommended as a first line therapy. Duragesic is a trade name of fentanyl transdermal therapeutic system which releases fentanyl, a potent opioid, slowly to the skin. For chronic opiate use, 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 aberrant 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. Duragesic patch was first mentioned in the 05/06/2014 report; it is unknown exactly when the patient initially started taking this medication. Per the treating physician the patient is able to do "Self-care activities, Walking, Sitting, Standing; Driving, Light house work, Cooking light meals and Quality time with family." There are no unmanaged side effects, no tolerance and no evidence of aberrant behavior are noted. Pain ranging from 10/10 to 5/10. In the case, the treating physician has clearly documented the 4 A's as required by the MTUS. The request is medically necessary.

Lidoderm 5% (700mg/patch) #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines lidoderm patches, Medications for chronic pain Page(s): 56-57, 60-61.

Decision rationale: According to the 10/15/2014 report, this patient presents with constant pain in the BL shoulder, right upper extremities that is "aching, sharp, shooting, stabbing and throbbing and "difficulty staying asleep due to pain." The current request is for Lidoderm 5% (700mg/patch) #60. This patch was first mentioned in the 05/06/2014 report; it is unknown exactly when the patient initially started taking this medication. The MTUS guidelines state that Lidoderm patches may be recommended for neuropathic pain that is peripheral and localized when trials of antidepressants and anti-convulsants have failed. Review of the provided reports show the patient has cervical neuropathic pain but this is not a localized condition and right shoulder pain that is peripheral and localized but not neuropathic. Lidoderm is not indicated for axial spinal pains. Furthermore, the treating physician does not discuss how this patch is used and with what effect and that the patient has failed a trial of antidepressants and anti-

convulsants . MTUS page 60 require documentation of pain and function when medications are used for chronic pain. The request is not medically necessary.

Savella 100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SNRIs (serotonin noradrenaline reuptake inhibitors) Page(s): 105.

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 : Milnacipran (Savella®).

Decision rationale: According to the 10/15/2014 report, this patient presents with constant pain in the BL shoulder, right upper extremities that is "aching, sharp, shooting, stabbing and throbbing and "difficulty staying asleep due to pain." The current request is for Savella 100mg #60. This medication was first mentioned in the 02/08/2013 report; it is unknown exactly when the patient initially started taking this medication. Regarding Milnacipran (Savella), ODG states "FDA has now approved milnacipran (Savella) for the management of fibromyalgia. As there is little to no evidence that the cause of fibromyalgia is related to industrial injuries, the use of Savella should be restricted to documented cases of fibromyalgia as part of an appropriate treatment plan."In reviewing the provided reports, the treating physician provided no documentation fibromyalgia and does not provide a medical rationale for the request of Savella. ODG guideline support the use of Savella in patient with fibromyalgia; which this patient does not presents with. The request is not medically necessary.

Rozerem 8mg #30 with 2 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 (ODG), Pain/Insomnia treatment

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

Decision rationale: According to the 10/15/2014 report, this patient presents with constant pain in the BL shoulder, right upper extremities that is "aching, sharp, shooting, stabbing and throbbing and "difficulty staying asleep due to pain." The current request is for Rozerem 8mg #30 with 2 refills. Regarding Ramelteon (Rozerem), the MTUS and ACOEM Guidelines do not address Rozerem; however, ODG Guidelines states that Rozerem is indicated for short-term (7-10day) use only for insomnia with difficulty of sleep onset. A short course of 7 to 10 days may be indicated for insomnia, however, the treating physician is requesting Rozerem #30 with 2 refills. The treating physician does not mention that this is for a short-term use. ODG Guidelines does not recommend long-term use of this medication. The request is not medically necessary.

Edluar 10mg #10: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain/Insomnia Treatment

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment, Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists).

Decision rationale: According to the 10/15/2014 report, this patient presents with constant pain in the BL shoulder, right upper extremities that is "aching, sharp, shooting, stabbing and throbbing and "difficulty staying asleep due to pain." The current request is for Edluar 10mg #10 and there is no mention of this medication in the provided reports. Regarding Zolpidem (Ambien), the MTUS and ACOEM Guidelines do not address Zolpidem; however, ODG Guidelines states that Zolpidem is indicated for short-term (7-10 day) use only for insomnia with difficulty of sleep onset. A short course of 7 to 10 days may be indicated for insomnia. In this case, the treating physician is requesting Edluar 10mg #10 which is appropriate. The ODG Guidelines recommend short-term use (no more than 10 day) of this medication. The request is medically necessary.