

<b>Case Number:</b>	CM15-0051154		
<b>Date Assigned:</b>	03/24/2015	<b>Date of Injury:</b>	04/01/2004
<b>Decision Date:</b>	05/13/2015	<b>UR Denial Date:</b>	03/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/18/2015

### 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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 50-year-old female who reported an injury on 04/01/2004. The mechanism of injury was not specifically stated. The current diagnoses include myalgia/myositis, cervical syndrome, cervical spondylosis and headache. The injured worker presented on 03/02/2015 for followup evaluation with complaints of neck pain, left upper extremity pain, spasticity and headaches. The injured worker also requested repeat Botox injections. The injured worker reported 7/10 pain with medication and 10/10 pain without medication. The current medication regimen includes diazepam 10 mg, fentanyl 50 mcg, gabapentin 300 mg, Zofran 4 mg and oxycodone 15 mg. The injured worker was status post spinal cord stimulator removal on 05/12/2008, as well as knee surgery. Upon examination there was severe guarding noted. There were no trigger points, tenderness or spasm identified. There was decreased cervical range of motion with left occipital tenderness with reproduction of headaches. Recommendations at that time included continuation of the current medication regimen. A Request for Authorization form was submitted on 03/02/2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone 15mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until a patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur. In this case, the injured worker has continuously utilized the above medication for an unknown duration. There was no documentation of objective functional improvement. The injured worker continues to report 7/10 pain with the current medication regimen. There is also no frequency listed in the request. As such, the request is not medically appropriate.

**Ondansetron HCL 4mg #30 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 (ODG).

**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, Ondansetron, Antiemetic.

**Decision rationale:** The Official Disability Guidelines do not recommend ondansetron for nausea and vomiting secondary to chronic opioid use. It is recommended for nausea and vomiting secondary to chemotherapy and radiation treatment. The injured worker does not meet criteria for the requested medication. There is also no frequency listed in the request. As such, the request is not medically appropriate.

**Gabapentin 300mg #180 with 1 refill:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-19.

**Decision rationale:** California MTUS Guidelines recommend antiepilepsy drugs for neuropathic pain. In this case, it is noted that the injured worker has continuously utilized the above medication for an unknown duration. There is no documentation of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically appropriate.

**Fentanyl 50mcg/hr/patch #15:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 44 and 74-82.

**Decision rationale:** California MTUS Guidelines do not recommend Duragesic as a first line therapy. It is FDA approved for management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. In this case, there is no evidence of a failure of first line treatment prior to the initiation of fentanyl patch. There is also no documentation of objective functional improvement despite the ongoing use of this medication. There is no frequent listed in the request. As such, the request is not medically appropriate.

**Diazepam 10mg #60 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

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

**Decision rationale:** California MTUS Guidelines state benzodiazepines and not recommended for long term use because long term efficacy is unproven and there is a risk of dependence. The injured worker does not maintain a diagnosis of anxiety disorder. The medical necessity for the requested medication has not been established. The request for 1 refill would not be supported as guidelines do not recommend long term use of this medication. There is also no frequency listed in the request. Therefore, the request is not medically appropriate.