

<b>Case Number:</b>	CM15-0088281		
<b>Date Assigned:</b>	05/12/2015	<b>Date of Injury:</b>	04/19/1990
<b>Decision Date:</b>	06/16/2015	<b>UR Denial Date:</b>	05/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2015

### 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

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(n) 57 year old female, who sustained an industrial injury on 4/19/90. She reported pain in the neck, lower back and bilateral shoulder. The injured worker was diagnosed as having bilateral complex regional pain syndrome, failed back syndrome and depression. Treatment to date has included a SynchroMed pump, OxyContin and Compazine (since at least 11/18/14) and an EMG study. The injured worker was hospitalized for acute respiratory failure from 1/4/15 to 1/10/15. As of the PR2 dated 2/3/15, the treating physician noted lung sounds clear throughout, tenderness over the bilateral shoulder muscles, sacroiliac joints, and venous ulcers on the bilateral lower extremities. The treating physician requested to continue OxyContin 80mg #360, Compazine 10mg #30 and Albuterol.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycontin 80mg #360:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids  
Page(s): 76-80.

**Decision rationale:** With regard to this request, the California Chronic Pain Medical Treatment Guidelines state the following about on-going management with opioids: "Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the '4 A's' (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs." Guidelines further recommend discontinuing opioids if there is no documentation of improvement in function and reduction in pain. In the progress reports available for review, the requesting provider did not adequately document monitoring of the four domains. Improvement in function was not clearly outlined. The MTUS defines this as a clinical significant improvement in activities of daily living or a reduction in work restrictions. Furthermore, the dosage of oxycontin is excess of guideline recommendations of 120mg of oral morphine equivalents. Based on the lack of documentation, medical necessity of this request cannot be established at this time. Although this opioid is not medically necessary at this time, it should not be abruptly halted, and the requesting provider should start a weaning schedule as he or she sees fit or supply the requisite monitoring documentation to continue this medication.

**Compazine 10mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Diagnosis and treatment of headache. Bloomington (MN): Institute for Clinical Systems Improvement; 2011 Jan. 84 p., Chlorpromazine, Intravenous Valproate Sodium, Intravenous Magnesium Sulfate or Prochlorperazine.

**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, Antiemetics.

**Decision rationale:** Regarding the request for an anti-emetic, the ODG Chronic Pain Chapter state the following: "Antiemetics: Not recommended for nausea and vomiting secondary to chronic opioid use. Recommended for acute use as noted below per FDA-approved indications. Nausea and vomiting is common with use of opioids. These side effects tend to diminish over days to weeks of continued exposure. Studies of opioid adverse effects including nausea and vomiting are limited to short-term duration (less than four weeks) and have limited application to long-term use. If nausea and vomiting remains prolonged, other etiologies of these symptoms should be evaluated for. The differential diagnosis includes 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. Recommendations based on these studies cannot be extrapolated to chronic non-malignant pain patients. There is no high-quality literature to support any one

treatment for opioid-induced nausea in chronic non-malignant pain patients. (Moore 2005)" Therefore, in this patient with chronic pain, the use of anti-emetics is not appropriate without a clearly defined etiology for the nausea. There is no indication that the patient has had a full gastrointestinal work-up to evaluate for other potential causes of nausea/vomiting. Given the guidelines and the facts of this case, this request is not medically necessary.

**Albuterol:** 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), Pulmonary: Asthma Medication (2014).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Uptodate Online, Albuterol Entry.

**Decision rationale:** Regarding the request for albuterol, the CA MTUS, ACOEM, and ODG do not address this issue. Therefore, an online database of evidenced-based medical guidelines was referenced. Albuterol is FDA approved for bronchospasm, exacerbation of asthma, and exercise-induced bronchospasm. In this injured worker, the documentation does not indicate that the respiratory issues are industrially related. There is no clear documentation of how often the inhaler is utilized and whether it has helped with symptoms. The scope of the independent medical review process does not include determination of causation, which should be referred to an agreed medical evaluation. Therefore, based upon the available documentation, this request is not medically necessary.