

Case Number:	CM14-0094943		
Date Assigned:	09/15/2014	Date of Injury:	07/16/2009
Decision Date:	10/15/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	06/23/2014

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 Family Medicine 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 47-year-old male who has submitted a claim for bilateral shoulder pain, bilateral wrist pain, carpal tunnel syndrome, and radial styloid tenosynovitis, right associated with an industrial injury date of 07/16/2009. Medical records from 04/15/2010 to 06/11/2014 were reviewed and showed that patient complained of bilateral shoulder and wrist pain graded 6-9/10. Physical examination of bilateral shoulders revealed restricted right shoulder ROM, tenderness over AC joints bilaterally, weakness of bilateral shoulder internal and external rotator, and positive Hawkin's and Speed's tests bilaterally. Physical examination of bilateral wrists revealed weakness of abductor pollicis brevis and positive Finkelstein's test on the right wrist. MRI of the left shoulder dated 07/29/2013 revealed rotator cuff tendinosis without tearing and prior acromioplasty with subacromial decompression. An MRI of the right shoulder dated 11/28/2011 revealed subacromial space spurring with delamination of supraspinatus tendon. EMG/NCV study of the upper extremities dated 01/14/2014 revealed right carpal tunnel syndrome. Treatment to date has included left shoulder acromioplasty (2000), right shoulder arthroplasty with acromioplasty (2012), and left shoulder acromioplasty and rotator cuff tear repair (April 2012), unspecified visits of physical therapy, Neurontin, Norco (dosage and quantity not specified; prescribed since 10/23/2012), Temazepam 15mg #30 (prescribed 02/05/2014), Fentanyl patches 25mcg/hr qty 5 (prescribed since 05/22/2014), levothyroxine, lidocaine, Paxil and omeprazole . Of note, patient does not attend physical therapy or perform HEP (05/22/2014). There was documentation of pain scale reduction from 9 to 6 with use of pain medications. It was not clear as to which pain medications provided pain relief. There was no documentation of functional outcome from Temazepam use. Utilization review dated 06/06/2014 denied the request for 10 Fentanyl patches 12mcg/hr because it did not appear that her pain had failed to respond to all other options. Utilization review dated 06/06/2014 denied the request for Norco 10/325mg #120

because previous reviews have already recommended weaning of Norco. Utilization review dated 06/06/2014 denied the request for Temazepam because the chronic use has exceeded guidelines recommendation. Utilization review dated 06/06/2014 denied the request for 30-day trial of TENS because it did not appear that the patient had failed other treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

10 Fentanyl Patches 12mcg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system)Fentanyl transdermal Page(s): 44, 93.

Decision rationale: The MTUS Chronic Pain Guidelines state that Duragesic (Fentanyl transdermal system) is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. In this case, the patient was prescribed Fentanyl patches 25mcg/hr qty 5 since 05/22/2014. There was documentation of continued use of oral opioids for pain relief. Fentanyl patches are only recommended for those requiring continuous opioid analgesia for pain that cannot be managed by other means. There is no clear indication for use of Fentanyl patches. Therefore, the request for 10 Fentanyl Patches 12mcg is not medically necessary.

Norco 10/325 mg # 120: Upheld

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

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

Decision rationale: The MTUS Chronic Pain Guidelines state that ongoing opioid treatment should include monitoring of analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors; these outcomes over time should affect the therapeutic decisions for continuation. In this case, the patient was prescribed Norco (dosage and quantity not specified) since 10/23/2012. There was documentation of pain scale reduction from 9 to 6 with use of pain medications. However, it was unclear as to whether pain relief was derived from Norco or other pain medications. There was no documentation of functional improvement as well. The guidelines do not recommend continuation of opioid treatment unless there is documentation of analgesia and functional improvement. Therefore, the request for Norco 10/325 mg # 120 is not medically necessary.

Temazepam 15mg: Upheld

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

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

Decision rationale: According to the MTUS Chronic Pain Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Tolerance to hypnotic effects develops rapidly. In this case, the patient was prescribed Temazepam 15mg #30 since 02/05/2014. However, there was no documentation of functional outcome from Temazepam use. Moreover, the long-term use of Temazepam beyond 4 weeks is not in conjunction with guidelines recommendation. There is no discussion provided as to why variance from the guidelines is needed. The request likewise failed to indicate the number of Temazepam to be dispensed. Therefore, the request for Temazepam 15mg is not medically necessary.

TENS unit - 30 day trial: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-116.

Decision rationale: According to the MTUS Chronic Pain Guidelines, TENS is not recommended as a primary treatment modality. A trial of one-month home-based TENS may be considered as a noninvasive conservative option. It should be used as an adjunct to a program of evidence-based functional restoration. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. Rental would be preferred over purchase during this trial period. In this case, the patient does not attend physical therapy or perform HEP. The Guidelines do not recommend TENS as solitary form of treatment. Furthermore, the request failed to specify the body part to be treated. Therefore, the request is not medically necessary and appropriate.