

Case Number:	CM14-0210738		
Date Assigned:	12/23/2014	Date of Injury:	07/16/2009
Decision Date:	02/19/2015	UR Denial Date:	11/17/2014
Priority:	Standard	Application Received:	12/16/2014

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: Indiana

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This employee is a 47 year old female with date of injury of 7/16/2009. A review of the medical records indicate that the patient is undergoing treatment for shoulder pain, wrist pain, cervical pain and intervertebral disc degeneration, and tenosynovitis. Subjective complaints include continued pain in the neck and shoulders and bilateral wrists. Objective findings include limited range of motion of the cervical spine and the right shoulder, positive Hawkin's test bilaterally; positive Finklestein's on the right; sensation reveals dull, diminished sensation to light touch over bilateral upper extremities. Treatment has included Neurontin, Temezepam, Lidoderm patches, Fentanyl patches, Norco, Lidocaine patches, and Paxil. The utilization review dated 11/17/2014 partially-approved Fentanyl patches, Norco, and Temezepam.

IMR ISSUES, DECISIONS AND RATIONALES

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

10 Fentanyl 12mcg/hr patch: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system), Opioids Page(s): 44, 79. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioids, Specific drug list.

Decision rationale: CA MTUS states and ODG agrees: "Not recommended as a first-line therapy. Duragesic is the trade name of a fentanyl transdermal therapeutic system, which releases fentanyl, a potent opioid, slowly through the skin . . . The FDA-approved product labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means." ODG does not recommend the use of opioids "except for short use for severe cases, not to exceed 2 weeks." The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." It is clear that the current treatment regimen is not beneficial to the patient. With the multiple pain medications, there is serious risk of opioid dependence. Weaning from this regimen should occur. As such, the request for Duragesic patch 25mcg (fentanyl) patch is not medically necessary.

120 Norco 10/325mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list, Hydrocodone/Acetaminophen.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute and Chronic), Low Back - Lumbar & Thoracic (Acute & Chronic), Opioids, Pain.

Decision rationale: ODG does not recommend the use of opioids for neck and low back pain "except for short use for severe cases, not to exceed 2 weeks." The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. As such, the question for Norco 325/10mg # 120 is not medically necessary.

30 Temazepam 15mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Temazepam Other Medical Treatment Guideline or Medical Evidence: Temazepam (Restoril) package insert.

Decision rationale: Temazepam is a benzodiazepine. MTUS states regarding benzodiazepine, "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. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks." ODG also notes "Not recommended" and "Criteria for use if provider & payor agree to prescribe anyway:1) Indications for use should be provided at the time of initial prescription.2) Authorization after a one-month period should include the specific necessity for ongoing use as well as documentation of efficacy." Medical records indicate that the patient has been on benzodiazepines far in excess of 4 weeks. Additionally, the request for three total months of benzodiazepine with no interim evaluation is not recommended. As such, the request for 1 Prescription of Temazepam 15mg #30 is not medically necessary.