

Case Number:	CM14-0173194		
Date Assigned:	10/24/2014	Date of Injury:	07/25/2008
Decision Date:	11/25/2014	UR Denial Date:	10/15/2014
Priority:	Standard	Application Received:	10/20/2014

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 of 07/25/08. Based on the 10/02/14 progress report provided by [REDACTED], the patient complains of neck pain that radiates to the right upper extremity and low back pain. Physical examination of the lumbar spine revealed tenderness over paraspinal muscles overlying the facet joints and trigger points noted over lower paraspinals. Her medications include Cyclobenzaprine, Fentanyl patch, Hydrocodone, Lisinopril, Mirtazapine, Nexium, Ondansetron HCL, Prozac, Vistaril, Voltaren and Wellbutrin. The physician stated in Request for Authorization Form dated 10/08/14 that Ondansetron is being prescribed for nausea. Patient is on modified work duty. Diagnosis as of 10/02/14 is lumbosacral radiculitis, cervical spondylosis, cervical radiculitis, duodenal ulcer disease, lumbar spondylosis, chronic pain and shoulder pain. The utilization review determination being challenged is dated 10/15/14. [REDACTED] is the requesting provider and he provided treatment reports from 08/15/14 - 10/02/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 10mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 41-42.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS "Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: The patient presents with neck pain that radiates to the right upper extremity and low back pain. The request is for Cyclobenzaprine 10mg #30. Her diagnosis dated 10/02/14 included cervical and lumbosacral radiculitis, cervical and lumbar spondylosis and chronic pain. MTUS pg. 63-66 states: "Muscle relaxants (for pain): Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. The most commonly prescribed antispasmodic agents are Carisoprodol, Cyclobenzaprine, Metaxalone, and Methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy." Guidelines do not suggest use of cyclobenzaprine for chronic use longer than 2-3 weeks. Cyclobenzaprine has been prescribed on 10/02/14, and it has been 2 weeks from the time of prescription until utilization review date of 10/15/14. Furthermore, the physician is requesting 30 quantities, which does not suggest short-term use. Recommendation is for denial. Guidelines do not suggest use of cyclobenzaprine for chronic use longer than 2-3 weeks. Cyclobenzaprine has been prescribed on 10/02/14, and it has been 2 weeks from the time of prescription until utilization review date of 10/15/14. Furthermore, treater is requesting 30 quantity, which does not suggest short-term use. Recommendation is for denial.

Fentanyl 75mcg/hr Transdermal Patch #15: Upheld

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 CRITERIA FOR USE OF OPIOIDS CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: The patient presents with neck pain that radiates to the right upper extremity and low back pain. The request is for Fentanyl 75mg/hr Transdermal patch #15. Her diagnosis dated 10/02/14 included cervical and lumbosacral radiculitis, cervical and lumbar spondylosis and chronic pain. 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 adverse 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. In this case, the physician does not state how Fentanyl patch reduces pain and allows patient to undergo activities of daily living, there are no numerical scales used; the four A's are not specifically addressed including discussions regarding aberrant drug behavior and specific ADL's, etc. Given the lack of documentation as required by MTUS, recommendation is for denial. In this case, treater does not state how Fentanyl patch reduces pain and allows patient to undergo activities of daily living, there are no numerical scales used; the four A's are not specifically addressed including discussions regarding aberrant drug behavior and specific ADL's, etc. Given the lack of documentation as required by MTUS, recommendation is for denial.

Hydrocodone/Acetaminophen 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75, 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: The patient presents with neck pain that radiates to the right upper extremity and low back pain. The request is for Hydrocodone/Acetaminophen 10/325mg #60. Her diagnosis dated 10/02/14 included cervical and lumbosacral radiculitis, cervical and lumbar spondylosis and chronic pain. 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 adverse 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. In this case, the physician does not state how Hydrocodone reduces pain and allows patient to undergo activities of daily living, there are no numerical scales used; the four A's are not specifically addressed including discussions regarding aberrant drug behavior and specific ADL's, etc. Given the lack of documentation as required by MTUS, recommendation is for denial. In this case, treater does not state how Hydrocodone reduces pain and allows patient to undergo activities of daily living, there are no numerical scales used; the four A's are not specifically addressed including discussions regarding aberrant drug behavior and specific ADL's, etc. Given the lack of documentation as required by MTUS, recommendation is for denial.

Ondansetron HCl 4mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 11th Edition, (web), 2014, Pain/Ondansetron (Zoltran)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Pain (Chronic) chapter, Antiemetics (for opioid nausea)

Decision rationale: The patient presents with neck pain that radiates to the right upper extremity and low back pain. The request is for Ondansetron HCL 4mg #30. Her diagnosis dated 10/02/14 included cervical and lumbosacral radiculitis, cervical and lumbar spondylosis and chronic pain. ODG guidelines have the following regarding Antiemetics: "ODG Guidelines, Pain (Chronic) chapter, Antiemetics (for opioid nausea): Not recommended for nausea and vomiting secondary to chronic opioid use." The physician stated in Request for Authorization Form dated 10/08/14 that Ondansetron is being prescribed for nausea. However, guidelines do not support this medication for nausea secondary to chronic Opioid use. Recommendation is for denial.

