

Case Number:	CM13-0030560		
Date Assigned:	11/27/2013	Date of Injury:	01/22/2007
Decision Date:	04/21/2014	UR Denial Date:	09/11/2013
Priority:	Standard	Application Received:	09/30/2013

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 Anesthesiology; has a subspecialty in Pain Management and is licensed to practice in Florida. 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 48-year-old male who reported an injury on January 22, 2007. The mechanism of injury was not stated. The patients diagnose includes two (2) level lumbar discopathy with right sided sciatica, status post lumbar laminectomy and discectomy with fusion in 2009, left leg pain, neurological problem, and status post hardware removal in 2011. [REDACTED] saw the patient on August 16, 2013. The patient reported significant low back pain with radiation to the right lower extremity. Physical examination revealed significant spasm with tenderness in the paralumbar musculature, reduced range of motion, positive straight leg raising, and decreased sensation at the L3-4 dermatomal levels on the right. Treatment recommendations included continuation of current medication and a urine drug screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 URINALYSIS BETWEEN 8/16/13 AND 8/16/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates, steps to avoid misuse/addiction..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 77, 89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing.

Decision rationale: The California MTUS Guidelines state drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. The Official Disability Guidelines state the frequency of urine drug testing should be based on documented evidence of risk stratification. As per the documentation submitted, the patient's injury was greater than six (6) years ago to date, and there is no indication of noncompliance or misuse of medication. There is also no indication that this patient falls under a high-risk category that would require frequent monitoring. Based on the clinical information received, the request for one (1) Urinalysis is non-certified.

1 PRESCRIPTION OF HYDROCODONE/APAP 10/325MG #60 BETWEEN 8/16/13 AND 11/9/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, , PAGE 74-82

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report significant low back pain with radiation to the right lower extremity. There is no change in the patient's physical examination that would indicate functional improvement. Based on the clinical information received, the request for one (1) prescription of Hydrocodone/APAP 10/325mg, #60, is non-certified.

1 PRESCRIPTION OF OMEPRAZOLE 20MG #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: The California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a non-selective NSAID. There is no indication of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the requested medication. As such, the request for one (1) prescription of Omeprazole 20mg, #100, is non-certified.