

<b>Case Number:</b>	CM13-0038440		
<b>Date Assigned:</b>	12/18/2013	<b>Date of Injury:</b>	10/05/2000
<b>Decision Date:</b>	03/05/2014	<b>UR Denial Date:</b>	10/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/25/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice, 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 physician 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 64-year-old female who reported an injury on 10/05/2000 due to a fall that resulted in right hip and low back injury and produced emotional stressors. The patient's chronic pain was managed with medications, psychological support, and trigger point injections. The patient's medication schedule included Anaprox, a Flector patch, Voltaren, Effexor, Neurontin, and Prilosec. The patient's most recent clinical findings included that there was no evidence or sign of withdrawal or overuse of medications, restricted range of motion of the lumbar spine with positive trigger points, and tenderness over the spinous process from the L3-S1. Evaluation of the right hip revealed limited range of motion secondary to pain and tenderness over the trochanter region. The patient's diagnoses included musculoligamentous sprain/strain of the lumbar spine, disc bulging in the lumbar spine, radiculopathy, chronic pain, sacroiliac dysfunction, and status post total hip replacement and status post total knee replacement. The patient's treatment plan included continued medication usage.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Urine Drug Testing-without suboxone:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

**Decision rationale:** The requested urine drug testing-without Suboxone is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient was previously denied narcotics due to inconsistent urine drug screens. The patient's medications were transitioned to a nonsteroidal anti-inflammatory drug and topical medications. California Medical Treatment Utilization Schedule recommends urine drug testing when patients are suspected of illicit drug use or there is a need for monitoring medication usage. The clinical documentation does not support that the patient is on any medications that require monitoring for aberrant behavior. Additionally, the physical evaluation indicates there are no signs of withdrawal or overdose to support the need for a urine drug screen. As such, the requested urine drug testing-without Suboxone is not medically necessary or appropriate.

**Psychological Testing (back depression and anxiety inventory):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluation Page(s): 100-101.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluation Page(s): 100.

**Decision rationale:** The requested psychological testing (back depression and anxiety inventory) is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient suffers from depression and anxiety related to her pain complaints. California Medical Treatment Utilization Schedule does recommend psychological evaluation for patients with chronic pain. However, the clinical documentation supports that the patient is being treated and psychiatric support, so the need for further evaluation is not clearly identified. As such, the requested psychological testing (back depression and anxiety inventory) is not medically necessary or appropriate.

**Weight Management Program (██████ weight program):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Diabetes Chapter, Lifestyle Modifications

**Decision rationale:** The requested weight management program (██████ weight program) is not medically necessary or appropriate. Official Disability Guidelines recommend a supervised weight management program when the patient is unable to achieve weight loss goals in a self-directed and self-managed weight loss program. The clinical documentation does not provide any evidence that the patient has attempted to self-manage nutritional intake or has failed to

progress through a home exercise program. As such, the requested weight management program (■■■■■ weight program) is not medically necessary or appropriate.

**Anaprox 550 mg, #60 take 1 daily QTY: 60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and NSAIDs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 60 and.

**Decision rationale:** The requested Anaprox 550 mg, #60 take 1 daily QTY: 60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends that continued use of medications in the management of chronic pain be supported by documentation of pain relief and functional benefit. The clinical documentation submitted for review does not provide any evidence that the patient has any functional benefit or pain relief resulting from the prescribed medication. As such, the requested Anaprox 550 mg, #60 take 1 daily QTY: 60 is not medically necessary or appropriate.

**Voltaren 1% gel (gm) apply to affected area twice a day QTY: 2: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The requested Voltaren 1% gel (gm) apply to affected area twice a day QTY: 2 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends topical nonsteroidal anti-inflammatory drugs when the patient is intolerant of oral formulations or when oral formulations are contraindicated to the patient. Additionally, this form of treatment is only recommended for a short course of time. The clinical documentation submitted for review does not provide any evidence that the patient has been intolerant of oral formulations of nonsteroidal anti-inflammatory drugs or that oral formulations of nonsteroidal anti-inflammatory drugs are contraindicated for the patient. Additionally, the clinical documentation indicates that the patient has been on this medication for an extended duration of time. As such, continued use would not be indicated. Therefore, Voltaren 1% gel (gm) apply to affected area twice a day QTY: 2 is not medically necessary or appropriate.