

Case Number:	CM13-0039605		
Date Assigned:	12/20/2013	Date of Injury:	01/30/1999
Decision Date:	02/28/2014	UR Denial Date:	10/18/2013
Priority:	Standard	Application Received:	10/28/2013

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 Physical Medicine and Rehabilitation 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 50-year-old female who reported an injury on 01/30/1999. A review of the medical records reveals the patient's diagnoses include clinically consistent lumbar radiculopathy, myofascial pain ICD9 code 729.1, chronic low back pain, lumbar sprain and strain, bilateral sacroiliitis, and greater trochanter bursitis. MRI of the lumbar spine dated 10/07/2005 revealed central disc protrusion at level of L5-S1 that was touching, but not compressing, the right S1 nerve root. Facet joint arthropathy was noted at multiple levels. There was a documented EMG/nerve conduction study done on 10/13/2005 that showed electrodiagnostic evidence consistent with left S1 abnormality. The most recent clinical note dated 12/13/2013 revealed the patient continued to complain of low back pain and reports having 5/10 of severity of pain. The patient states that most of her pain is on the right side, which she describes as constant achy type of pain. The patient expressed fear of going through withdrawals because her medications were not being approved, and also she expressed fear of possible seizure activity without her medications. Objective findings upon assessment revealed spasms to the lumbar paraspinal muscles and stiffness noted to the lumbar spine with noted tenderness at bilateral posterior superior iliac spine, which is worse on the right side. Sensory was normal to light touch in bilateral lower extremities. Straight leg raise is non-contributory to bilateral lower extremities. The patient was advised to continue her medication regimen as previously ordered.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl Patch 50 mg #15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary.

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

Decision rationale: In reference to the decision for Fentanyl Patch 50 mg #15, it is not medically necessary. Per California MTUS Guidelines, Duragesic patches are a potent opioid that releases the medication slowly through the skin. It is used for treatment of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. The patient has been taking the requested medication for an extended amount of time and continues to have complaints of severe pain with decreased functional abilities. Therefore, the medical necessity for continuation of the Fentanyl Patch 50 mg #15 cannot be determined at this time and the request is non-certified. While the requested medication does not meet medical necessity, it is expected that the ordering provider will follow recommended medication Guidelines for safe discontinuation.

Carisoprodol 350 mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASMODICS Page(s): 65.

Decision rationale: Per California MTUS Guidelines, antispasmodics are not recommended for longer than a 2 to 3 week period of treatment. The requested medication mechanism of action is unknown. The patient has been taking the requested medication for an extended amount of time without significant change in her functional level or decrease in her pain. Therefore, the medical necessity for continuation of the medication cannot be determined at this time. It also is noted that the recommended length of time for treatment with this medication is 2 to 3 weeks. The patient has also exceeded that time. Therefore, the request for Carisoprodol 350 mg #60 is non-certified. While the requested medication does not meet medical necessity based on information presented, it is expected that the ordering provider will follow recommended medication Guidelines for safe discontinuation.

Norco 10/325 mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-79.

Decision rationale: Per California MTUS Guidelines, when there is ongoing management with opioids it is required that there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects of the requested medication. A pain assessment, which would include the current pain, the least reported pain over the period since the last assessment, average pain, and intensity of pain after taking the opioid is also required. None of this information was provided in the medical records. There is no documentation of any increased functional capabilities or decrease in the patient's pain. The patient continues to have significant pain; therefore, the medical necessity for continued use of Norco 10/325 cannot be determined and the medication request is non-certified. While the requested medication does not meet medical necessity based on information presented, it is expected that the ordering provider will follow recommended medication Guidelines for safe discontinuation

Zolpidem 10 mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Zolpidem (Ambien®).

Decision rationale: Per the Official Disability Guidelines, zolpidem is a prescription short acting non-benzodiazepine hypnotic, which is approved for short-term use, usually 2 to 6 weeks for treatment of insomnia. The patient has been taking the requested medication for an extended length of time, which exceeds the 2 to 6 week time period, with no relief of her symptoms. Therefore, the medical necessity for continued use of zolpidem 10 mg cannot be determined at this time and the request is non-certified

Lidoderm Patch #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm® (lidocaine patch), Page(s): 56-57.

Decision rationale: Per California MTUS Guidelines, it is stated that the requested medication is recommended for localized peripheral pain after there has been evidence of a trial of a first line therapy to include antidepressants or anti-epileptic drugs such as gabapentin or Lyrica. It is not a first line treatment. There is no clinical documentation provided in the medical records of any previous attempts at a first line therapy treatment with antidepressants or with gabapentin or Lyrica at this time. The patient has stated that the use of Lyrica does help with her pain; therefore, the medical necessity for continued use of a Lidoderm patch cannot be determined at this time and the request is non-certified.

for Random Drug screening: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The decision for Random Drug screening, it is not medically necessary. Per California MTUS Guidelines, it is suggestive that urine drug screens are used to assess for the use of or presence of illegal drugs. It is also used to identify the use of undisclosed substances and uncover diversion of prescribed substances. This test should be used in conjunction with other clinical information when decisions are made to continue, adjust, or discontinue treatment. There has been no adjustment or discontinuation of the patient's medication prior to these requests that would require the use of a random drug screen at this time. There were no clinically documented signs that would suggest the patient was using any illegal drugs or unprescribed substances. Therefore, the medical necessity for a random drug screen cannot be determined and the request is non-certified.