

Case Number:	CM13-0053295		
Date Assigned:	12/30/2013	Date of Injury:	06/09/1995
Decision Date:	04/30/2014	UR Denial Date:	09/13/2013
Priority:	Standard	Application Received:	10/18/2013

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 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 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:

This 58 year-old female sustained an injury on 6/9/95 while employed by [REDACTED]. Requests under consideration include ONE INTERLAMINAR EPIDURAL STEROID INJECTION AT C4-C5 AND C5-C6, ONE PRESCRIPTION OF HYDROCODONE/APAP 10/325 MG #45, ONE PRESCRIPTION OF TRAZODONE 50 MG #60, and ONE MED PANEL. Report of 8/8/13 from the provider noted patient with chronic neck and upper extremity pain radiating to right hand rated at 7/10 with left upper extremity discomfort. Exam showed cervical paraspinal tenderness; decreased range of motion in cervical spine with decreased right C6, C7 sensory; 5-/5 motor strength in right wrist extensors, flexors as well as grip; and hyperreflexic reflexes. Diagnoses included cervical radiculopathy; facial numbness; right shoulder sprain/strain; severe C3-4 cervical spinal stenosis; elevated liver enzymes. The patient reported medications assist to improve functional and sleep, decrease pain; had inconsistent urine drug screen with prescribed medications. Requests above were non-certified on 9/13/13 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE INTERLAMINAR EPIDURAL STEROID INJECTION AT C4-C5 AND C5-C6:

Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 47.

Decision rationale: This 58 year-old female sustained an injury on 6/9/95 while employed by [REDACTED]. Requests under consideration include ONE INTERLAMINAR EPIDURAL STEROID INJECTION AT C4-C5 AND C5-C6, ONE PRESCRIPTION OF HYDROCODONE/APAP 10/325 MG #45, ONE PRESCRIPTION OF TRAZODONE 50 MG #60, and ONE MED PANEL. Report of 8/8/13 from the provider noted patient with chronic neck and upper extremity pain radiating to right hand rated at 7/10 with left upper extremity discomfort. Diagnoses included cervical radiculopathy; facial numbness; right shoulder sprain/strain; severe C3-4 cervical spinal stenosis; elevated liver enzymes. The patient reported medications assist to improve functional and sleep, decrease pain; had inconsistent urine drug screen with prescribed medications. Review indicated MRI of the cervical spine showed mild canal stenosis and C3-4 and mild-moderate at C4-5; however, does not correlate with clinical findings of dermatomal sensory loss at C6-7 with some mild motor weakness of 5-/5 of wrist extensors/flexors. Additionally, guidelines recommend no more than one interlaminar should be injected at one session. Submitted reports have also not adequately demonstrated failed conservative trials or functional benefit from previous pain interventions to support for request outside guidelines criteria. The ONE INTERLAMINAR EPIDURAL STEROID INJECTION AT C4-C5 AND C5-C6 is not medically necessary and appropriate.

ONE PRESCRIPTION OF HYDROCODONE/APAP 10/325MG #45: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-96.

Decision rationale: This 58 year-old female sustained an injury on 6/9/95 while employed by [REDACTED]. Requests under consideration include ONE INTERLAMINAR EPIDURAL STEROID INJECTION AT C4-C5 AND C5-C6, ONE PRESCRIPTION OF HYDROCODONE/APAP 10/325 MG #45, ONE PRESCRIPTION OF TRAZODONE 50 MG #60, and ONE MED PANEL. The patient has received a partial-certification for 30-day supply after the inconsistent findings of the urine toxicology screening to assist in the weaning process. Per the MTUS Guidelines cited, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in work status. There is no evidence presented of action from inconsistent random drug testing or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance.

The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain. The ONE PRESCRIPTION OF HYDROCODONE/APAP 10/325 MG #45 is not medically necessary and appropriate.

ONE PRESCRIPTION OF TRAZODONE 50MG #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

Decision rationale: Trazodone hydrochloride (Desyrel) is an antidepressant chemically unrelated to tricyclic, tetracyclic, or other known antidepressant agents and is indicated for the treatment of major depression. MTUS Medical Treatment Guidelines specifically do not recommend for Trazodone. Tolerance may develop and rebound insomnia has been found even after discontinuation, but may be an option in patients with coexisting depression that is not the case here. Submitted reports have not demonstrated functional benefit derived from the previous treatment rendered for this chronic 1995 injury. The ONE PRESCRIPTION OF TRAZODONE 50 MG #60 is not medically necessary and appropriate.

ONE MED PANEL: Upheld

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

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

Decision rationale: The med panel consists of a urine drug screen which is recommended by guidelines to monitor for patient's safety while using ongoing controlled substance twice yearly for misuse of controlled substance or illicit drug use in patients with chronic non-malignant pain. As opioids are not medically necessary and appropriate for this chronic injury of 1995 without functional benefit from previous treatment use along with no reference to safety precautions taken for the inconsistent recent UDS, the current med panel request does not meet criteria for repeating the study. The ONE MED PANEL is not medically necessary and appropriate.