

Case Number:	CM13-0070728		
Date Assigned:	01/08/2014	Date of Injury:	01/03/2005
Decision Date:	04/21/2014	UR Denial Date:	12/26/2013
Priority:	Standard	Application Received:	12/26/2013

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 Georgia. 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 claimant presents with chronic low back pain following a work-related injury on January 3, 2005. The claimant was diagnosed with lumbosacral disc degeneration, thoracic and lumbar radiculitis, lumbago, and chronic pain disorder. On February 18, 2013, the claimant complains of chronic low back pain, sciatic pain, and radiating pain across the back and into the left buttocks. The claimant reported that the H wave and medications including Lidoderm and Vistaril helps. The physical exam was significant for diminished range of motion, tenderness of the left posterior sacroiliac spine, positive Faber's, and positive Gaenslen's test on the left. The claimant's medications include Kadian, Percocet, Motrin, and Lidoderm patch. The claimant had a urine drug screen on September 9, 2013 revealing nicotine and Percocet components. The provider recommended a CMP, CBC, urinalysis and continue medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

CMP AND CBC: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Lab Tests Online

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 8 and 11.

Decision rationale: The requested CMP and CBC are not medically necessary. The Chronic Pain Medical Treatment Guidelines state that clinical judgment shall be applied to determine frequency and intensity and selection of treatment must be tailored for the individual case. The claimant was diagnosed with lumbosacral disc degeneration, thoracic and lumbar radiculitis, lumbago, and chronic pain. The requested test will not add to a diagnosis or treatment associated with the claimant's work related injury. Therefore, the requested tests are not medically necessary and appropriate.

RETROSPECTIVE AND PROSPECTIVE REVIEW OF AN URINE ANALYSIS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (OGD)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Substance Abuse Page(s): 108. Decision based on Non-MTUS Citation Official Disability Guidelines (OGD)

Decision rationale: The requested retrospective and prospective request for a urine analysis is not medically necessary. The Chronic Pain Medical treatment Guidelines state that a urine drug screen is used to assess for the use or the presence of illegal drugs as an option in patients on chronic opioids. The guidelines recommend screening for the risk of addiction prior to initiating opioid therapy; however, these guidelines did not address the type of UDS to perform, or the frequency of testing. The ODG recommends UDS testing using point of care immunoassay testing prior to initiating chronic opioid therapy, and if this test is appropriate, confirmatory laboratory testing is not required. Further urine drug testing frequency should be based on documented evidence of risk stratification including use of the testing instrument with patients at low risk of addiction, aberrant behavior. There is no reason to perform confirmatory testing unless tests is an appropriate orders on expected results, and if required, a confirmatory testing should be for the question drugs only. If urine drug test is negative for the prescribed scheduled drug, confirmatory testing is strongly recommended for the question drug. In this case, the provider did not document risk stratification using a testing instrument as recommended in the Chronic Pain Medical Treatment Guidelines to determine frequency of UDS testing. Therefore, the requested services are not medically necessary and appropriate.

RETROSPECTIVE AND PROSPECTIVE USE OF PERCOCET 7.5/325 MG #33: Upheld

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

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

Decision rationale: Percocet 7.5/325mg # 55 is not medically necessary. The Chronic Pain Medical Treatment Guidelines state that opioids for chronic pain is recommended for short-term use after failure of first line non-pharmacologic and medication option including Acetaminophen and NSAIDS. Additionally, the guidelines states that weaning of opioids are recommended if (a)

there are no overall improvement in function, unless there are extenuating circumstances (b) continuing pain with evidence of intolerable adverse effects (c) decrease in functioning (d) resolution of pain (e) if serious non-adherence is occurring (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. Records show that the claimant continued to report pain. The claimant has long-term use with this medication, with possible non-adherence given an inappropriate urine drug screen and there was a lack of improved function. Therefore, the requested medication is not medically necessary and appropriate.

RETROSPECTIVE AND PROSPECTIVE USE OF VISTARIL 25MG #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drugs.com

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physician Desk Reference

Decision rationale: Vistaril 25mg #30 is not medically necessary. According to the Physician Desk Reference Vistaril reduces activity in the central nervous system. Vistaril also acts as an antihistamine that reduces electrochemical histamine in the body. This medication is also used as a sedative to treat anxiety and tension. The claimant's medical records do not document an appropriate indication for this medication. Therefore, the requested medication is not medically necessary and appropriate.

RETROSPECTIVE AND PROSPECTIVE USE OF LIDODERM 5% PATCH #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: Lidoderm 5% patches are not medically necessary. The Chronic Pain Medical Treatment Guidelines do not cover topical analgesics that are largely experimental in use with a few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. Additionally, the guidelines state that topical analgesics such as lidocaine are recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (anti-depressants or AED). The guidelines state that topical analgesic such as Lidocaine is not recommended for non-neuropathic pain. The claimant was not diagnosed with neuropathic pain and there is no documentation of physical findings or diagnostic imaging confirming the diagnosis. Therefore, the requested medication is not medically necessary and appropriate.

RETROSPECTIVE AND PROSPECTIVE USE OF MOTRIN 600 MG (1X4): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs
Page(s): 67.

Decision rationale: Motrin is not medically necessary. Per the Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain so to prevent or lower the risk of complications associate with cardiovascular disease and gastrointestinal distress. The medical records do no document the length of time the claimant has been on Naproxen or if there was any previous use of NSAIDs. Therefore, the requested medication is therefore not medically necessary and appropriate.