

Case Number:	CM14-0011302		
Date Assigned:	02/21/2014	Date of Injury:	04/21/2011
Decision Date:	06/25/2014	UR Denial Date:	01/22/2014
Priority:	Standard	Application Received:	01/28/2014

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 Internal Medicine 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:

Progress report dated 12/23/2013 documented the patient with complaints of low back pain and right hip pain radiating to the groin and the anterior thigh. He has been going through physical therapy that has been helpful. The pain is about an 8/10 to 9/10 before medications, coming down to 5/10 or 7/10 with medication. He does not have any side effects on the medication except for constipation, which he takes Colace for. The medication allows him to walk and stretch. He is not working. Current medications include: 1. Percocet 2. Morphine sulfate 3. Neurontin 4. Ambien 5. Colace Objective findings on exam reveal the patient is moving better today than at last appointment. Diagnoses: 1. Chronic right hip joint, status post right hip arthroscopic surgery on 10/09/2012. 2. Chronic low back pain. Plan: 1. MS Contin 15 mg bid 2. Percocet 10/325 mg 3. Neurontin 800 mg 4. Colace 100 mg 5. Urine Drug Screen The Utilization Review (UR) report dated 01/22/2014 denied the request for Testim Gel because the provider indicates this medication would be significantly helpful to help with his diminished energy, mood and pain levels. This documentation does not contain any laboratory values indicating this patient to have low testosterone levels for which this medication would be seen as medically necessary. The requests for Percocet and MS Contin are denied for 1 month to allow for documentation of the recently approved urine drug screening and for the provider to submit a signed narcotic contract or alternatively to allow for tapering prior to discontinuation of the medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

PERCOCET: 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): 75-94.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommends chronic opioid therapy when the 4 A have been met. These are sufficient analgesia has been achieved, improvement in activities of daily living, no significant adverse side effects, and no aberrant drug taking behavior. Although the patient appears to have possibly met these criteria. The frequency, dose, and number of tablets were not specified in the request. These are an essential component of the request for opioids to ensure there are frequent visits with patient's on chronic opioid therapy. Given the lack of details regarding the requested prescription the request is not medically necessary and appropriate.

MS CONTIN: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Opioids Page(s): 75-94.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommends chronic opioid therapy when the 4 A's have been met. These are sufficient analgesia has been achieved, improvement in activities of daily living, no significant adverse side effects, and no aberrant drug taking behavior. The patient appears to have possibly met these criteria, however the frequency, dose, and number of tablets were not specified in the request. These are an essential component of the request for opioids to ensure there are frequent visits with patient's on chronic opioid therapy. Given the lack of details regarding the requested prescription the request is not medically necessary and appropriate.

TESTIM GEL: 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), Pain, Testosterone replacement for hypogonadism (related to opioids).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Testosterone replacement for hypogonadism (related to opioids)

Decision rationale: CA MTUS guidelines do not specifically discuss the issue in dispute. The ODG guidelines recommend testosterone replacement in limited circumstances for patients on

chronic high dose opioids. The patient should have documented low testosterone levels with signs and/or symptoms of hypogonadism such as gynecomastia. If needed it should be prescribed by physicians with special knowledge in the field such as an Endocrinologist. There was insufficient documentation that showed the patient had low testosterone levels and signs/symptoms consistent with hypogonadism. Based on the ODG guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.