

Case Number:	CM14-0132492		
Date Assigned:	08/22/2014	Date of Injury:	09/03/2003
Decision Date:	10/02/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	08/19/2014

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 Family 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:

This is a 45-year-old female patient who reported an industrial injury on 9/23/2003 attributed to the performance of her usual and customary job tasks reported as driving along and experiencing stiffness in her right leg which resulted in her inability to continue driving. The patient complains of low back pain and left knee pain. The objective findings on examination included tenderness to palpation; muscle spasm; facet pain; range of motion lumbar spine reduced; allodynia in the right knee. The patient has been treated with medications; physical therapy; chiropractic care; activity modification. The patient is being treated for chronic pain issues to the right knee, lower back, right hip, and right foot. The patient was prescribed bilateral SI joint injections; coccygeal injection and gabapentin 100 mg PO TID #90 which were certified. The patient was also prescribed a psych clearance for a spinal cord stimulator; urine toxicology screen; fentanyl 50 mcg/hr #15; Imitrex 50 mg #30; Naprosyn 550 mg b.i.d. #60; Prilosec 20 mg #60 and Estazolam 2 mg one QHS #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Psychiatric clearance for the spinal cord stimulator trial: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines spinal cord stimulators Page(s): 105-07. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter psychological evaluations IDDS and SCS; spinal cord stimulators;

Decision rationale: The request for authorization of a SCS for the lumbar spine is not supported with objective evidence to support medical necessity of a clinical trial with a spinal cord stimulator. The patient is not documented to meet the criteria recommended by the California MTUS for the trial of a SCS. The use of the SCS is noted to be a treatment of last resort. The consideration of a spinal cord stimulator trial is premature in the treatment plan and as such, a psychological clearance for the spinal cord stimulator trial is not medically necessary.

Urine toxicology screening: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Steps to Avoid Misuse/Addiction. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Urine Drug Testing (UDT)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80-82. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter--drug testing; screening for addiction; Urine drug testing

Decision rationale: The provider has requested a drug screen due without a rationale to support medical necessity other than to help with medication management. There was no patient data to demonstrate medical necessity or any objective evidence of cause. There is no provided rationale by the ordering physician to support the medical necessity of the requested urine drug screen in relation to the cited industrial injury, the current treatment plan, the prescribed medications, and reported symptoms. There is no documentation of patient behavior or analgesic misuse that would require evaluation with a urine toxicology or drug screen.

Fentanyl 50 mcg, QTY: 15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter opioids American College of Occupational and Environmental Medicine (ACOEM), 2ndEdition, (2004) chapter 6 pages 114-116; chapter 12 pages 300-306

Decision rationale: The chronic use of Fentanyl patches is not recommended by the California MTUS, the ACOEM Guidelines, or the Official Disability Guidelines for the long-term treatment of chronic knee pain. The updated chapter of the ACOEM Guidelines and the third edition of the ACOEM Guidelines stated that both function and pain must improve to continue the use of opioids. The prescription of opiates on a continued long-term basis is inconsistent with the California MTUS and the Official Disability Guidelines recommendations for the use of opiate

medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs and OTC analgesics for the treatment of chronic back and leg pain. There is no provided evidence that the patient has received benefit or demonstrated functional improvement with Fentanyl patches. As such, the request is not medically necessary.

Imitrex 50mg, QTY: 30: 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), Head Chapter, Triptans

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: General disciplinary guidelines for the practice of medicine

Decision rationale: The requesting physician has provided no rationale for the prescription of Imitrex (Sumatriptan Succinate) or provided a nexus to the cited mechanism of injury. There is no evidence that migraine headaches are part of the industrial injury. There is no provided rationale to support medical necessity for the prescribed Sumatriptan for the effects of the industrial injury. There is no demonstrated medical necessity for the use of Imitrex for the effects of the industrial injury and there is no rationale supported with objective evidence by the treating physician to demonstrate medical necessity. There is no demonstrated functional improvement and no establish reduction in pain levels. As such, the request is not medically necessary.

Naprosyn 550mg, QTY: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (Non-Steroidal Anti-Inflammatory Drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-inflammatory medication Page(s): 67-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter-medications for chronic pain; NSAIDs

Decision rationale: The use of Naprosyn 550 mg #60 is consistent with the currently accepted guidelines and the general practice of medicine for musculoskeletal strains and injuries; however, there is no evidence of functional improvement or benefit from this NSAID. There is no evidence that OTC NSAIDs would not be appropriate for similar use for this patient. The prescription of Naprosyn is not supported with appropriate objective evidence as opposed to the NSAIDs available OTC. The prescription of Naproxen should be discontinued in favor of OTC NSAIDs. There is no provided evidence that the available OTC NSAIDs were ineffective for the treatment of inflammation. As such, the request is not medically necessary.

Prilosec 20mg, QTY: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (Non-Steroidal Anti-Inflammatory Drugs) GI (Gastrointestina.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-inflammatory medication Page(s): 67-68.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter-medications for chronic pain; NSAIDs

Decision rationale: The protection of the gastric lining from the chemical effects of NSAIDs is appropriately accomplished with the use of the proton pump inhibitors such as Omeprazole. The patient is documented to be taking NSAIDs--Naprosyn; however, there are no demonstrated GI side effects. There is no industrial indication for the use of Omeprazole due to "stomach issues" or stomach irritation. The proton pump inhibitors provide protection from medication side effects of dyspepsia or stomach discomfort brought on by NSAIDs. The use of Omeprazole is medically necessary if the patient were prescribed conventional NSAIDs and complained of GI issues associated with NSAIDs. Whereas 50% of patient taking NSAIDs may complain of GI upset, it is not clear that the patient was prescribed Omeprazole automatically. The prescribed opioid analgesic, not an NSAID, was accompanied by a prescription for Omeprazole without documentation of complications. There were no documented GI effects of the NSAIDs to the stomach of the patient and the Omeprazole was dispensed or prescribed routinely. There is no documented functional improvement with the prescribed Omeprazole. As such, the request is not medically necessary.

Estazolam 2mg, QTY: 30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter--insomnia Other Medical Treatment Guideline or Medical Evidence: Benzodiazepines

Decision rationale: The prescription for Estazolam is recommended only for the short-term treatment of insomnia for two to six weeks. The treating physician has provided ProSom/Estazolam to the patient every night for the effects of the industrial injury 11 years ago. There is no medical necessity for ProSom (Estazolam) for this patient. The prescription is inconsistent with the California MTUS guidelines. The treating physician does not provide any rationale to support the medical necessity of Estazolam for insomnia or documented the treatment of insomnia to date. The patient is being prescribed the Estazolam for insomnia 11 years after the date of injury. There is no provided subjective/objective evidence to support the continued use of Estazolam on an industrial basis for this patient. The patient has exceeded the recommended time period for the use of this short-term sleep aide. The California MTUS does not recommend benzodiazepines for the treatment of insomnia. There is no documentation of alternatives other than Estazolam have provided for insomnia or that the patient actually requires sleeping pills. The patient is not documented with objective evidence to have insomnia or a sleep disorder at this point in time or that conservative treatment is not appropriate for treatment. There

is no evidence that conservative treatment including diet and exercise have failed for the treatment of sleep issues. As such, the request is not medically necessary.