

Case Number:	CM14-0176159		
Date Assigned:	11/03/2014	Date of Injury:	10/22/2010
Decision Date:	12/18/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/23/2014

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 Occupational 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:

The patient is a 51-year-old female who has submitted a claim for brachial neuritis or radiculitis, lumbar disc protrusion, bilateral carpal tunnel syndrome, and bilateral knee chondromalacia patella, associated with an industrial injury date of 10/22/2010. Medical records from 2013 to 2014 were reviewed. The patient complained of constant neck pain radiating to upper extremities, and associated with a numbness and tingling sensation. The patient also experienced low back pain radiating to lower extremities. There were no side effects noted. The patient had no gastrointestinal symptoms. The pain was rated 10/10 in severity, and was relieved to 6-7/10 with medications. Physical examination of the cervical spine showed tenderness and limited motion. Positive Phalen's and Tinel's signs were noted. Examination of the lumbar spine showed limited motion, spasm, and tenderness. Straight leg raise test was positive bilaterally. Sensation was diminished at right C6 and C8 dermatomes. Urine drug screen was performed on 8/19/2014 with no disclosure of results. Treatment to date has included psychotherapy, acupuncture, physical therapy, wrist brace, lumbar support belt, and medications such as Colace, Norco, Valium, Xanax, Thyroxine (since 2013), and vitamin B12 injection on 8/19/2014. The utilization review from 9/26/2014 denied the request for urine drug screen (retrospective); denied Colace 100mg, #120; denied Norco 10/325 mg, #120; denied Valium 10mg, #30; denied Xanax 1 mg, #30; denied Thyroxine (Synthroid) 137 mg, #30; denied omeprazole 20mg, #60; denied acupuncture two times a week for three weeks; and denied B12 injection. Reasons for denial were not made available.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Urine drug screen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

Decision rationale: Page 78 of the CA MTUS Chronic Pain Medical Treatment Guidelines indicate that the urine drug screens are recommended as an option to assess order use or presence of illegal drugs and as ongoing management for continued opioid use. Screening is recommended randomly at least twice and up to 4 times a year. In this case, current medications include Colace, Norco, Valium, Xanax, and Thyroxine. However, urine drug screen from 8/19/2014 was already accomplished without disclosure of results. There was no clear rationale for repeating drug screen. No aberrant drug behavior was likewise noted to warrant such. Moreover, the present request as submitted failed to specify retrospective date for review. Therefore, the request for urine drug screen (retrospective) was not medically necessary.

Colace 100mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Initiating Therapy Page(s): 77.

Decision rationale: Page 77 of CA MTUS Chronic Pain Medical Treatment Guidelines states that with opioid therapy, prophylactic treatment of constipation should be initiated. Docusate is a stool softener. In this case, the patient is on opioid therapy since 2013; hence, prophylactic treatment for constipation has been established. However, a simultaneous request for Norco has been deemed not medically necessary. There is no clear indication for certifying a stool softener at this time. Therefore, the request for Colace 100mg #120 is not medically necessary.

Norco 10/325mg #120: Upheld

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

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

Decision rationale: As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic

decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, the patient is prescribed Norco since 2013. The pain is rated 10/10 in severity and relieved to 6-7/10 with medications. No side effects are reported. However, there is no documentation concerning objective functional benefit with medication use. There is likewise no disclosure of results of urine drug screen performed on 8/19/2014. Therefore, the request for Norco 10/325mg #120 is not medically necessary.

Valium 10mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: As stated on page 24 of CA MTUS Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. In this case, the patient is prescribed Valium since 2013. However, there is no documentation concerning functional improvement derived from its use. Furthermore, it is not recommended for long-term use as stated by the guidelines. Lastly, the patient is also prescribed Xanax and there is no discussion why two benzodiazepines are needed. Therefore, the request for the request for Valium 10mg #30 is not medically necessary.

Xanax 1mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: As stated on page 24 of CA MTUS Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. In this case, the patient is prescribed Xanax since 2013. However, there is no documentation concerning functional improvement derived from its use. Furthermore, it is not recommended for long-term use as stated by the guidelines. Lastly, the patient is also prescribed Valium and there is no discussion why two benzodiazepines are needed. Therefore, the request for Xanax 1mg #30 is not medically necessary.

Thyroxine (Synthroid): Upheld

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

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: US Food and Drug Administration (Synthroid)

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the US Food and Drug Administration was used instead. The FDA states Synthroid (levothyroxine) is a replacement for a hormone that is normally produced by thyroid gland to regulate the body's energy and metabolism. Synthroid treats hypothyroidism. In this case, patient is prescribed Synthroid since 2013. However, there is no evidence of a thyroid disorder. There is likewise no laboratory testing of T3/T4 levels to corroborate the necessity of thyroid replacement therapy. The medical necessity cannot be established due to insufficient information. The request likewise failed to specify quantity to be dispensed. Therefore, the request for Thyroxine (Synthroid) is not medically necessary.

Omeprazole 20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms, and Cardiovascular Risk Page(s): 68.

Decision rationale: As stated on page 68 of CA MTUS Chronic Pain Medical Treatment Guidelines, clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors: age > 65 years, history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; or on high-dose/multiple NSAIDs. Patients with intermediate risk factors should be prescribed proton pump inhibitors (PPI). In this case, patient has been on omeprazole since 2013. However, there is no subjective report of heartburn, epigastric burning sensation or any other gastrointestinal symptoms that may corroborate the necessity of this medication. Furthermore, patient does not meet any of the aforementioned risk factors. The guideline criteria are not met. Therefore, the request for omeprazole 20mg #60 is not medically necessary.

Acupuncture 2 x week x 3 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: CA MTUS Acupuncture Medical Treatment Guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture treatments may be extended if functional improvement is documented. The frequency and duration to produce functional improvement is 3 - 6 treatments, frequency of 1 - 3 times per week, and duration of 1 - 2 months. It may be extended if functional improvement is documented. In this case, patient has received acupuncture treatment in the past; however, the exact number of visits is not documented in the medical records submitted. There is no documentation stating the pain reduction, functional improvement or decreased medication-usage associated with acupuncture. The medical necessity cannot be established due to insufficient information. Moreover, body part to be treated is not specified. Therefore, the request for acupuncture 2 x week x 3 weeks is not medically necessary.

B12 injection: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Vitamin B

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guidelines (ODG) Pain chapter, was used instead. ODG states that vitamin B is not recommended. It is frequently used for treating peripheral neuropathy but its efficacy is not clear. In this case, patient has persistent neck and back pain despite conservative management. However, there is no evidence to support vitamin B12 injection. There is no discussion concerning need for variance from the guidelines. Moreover, the patient had a vitamin B12 injection on 8/19/2014; response to treatment was not documented. Therefore, the request for vitamin B12 injection is not medically necessary.