

Case Number:	CM14-0026104		
Date Assigned:	06/13/2014	Date of Injury:	07/18/2001
Decision Date:	07/23/2014	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	02/28/2014

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 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:

The patient is a 42 year-old female who was injured on 07/18/2001. The mechanism of injury is unknown. The patient underwent a back surgery in 2006 and 2008. The patient's medications as of 01/31/2014 include Alprazolam 2 mg, Fentanyl 100 mcg/hr, Fiorinal 50 mg/325 mg-40mg, Imitrex 100 mg, Lunesta 3 mg, Marinol 5 mg, Nuvigil 250 mg, Percocet, phernergan suppository, Protonix 40 mg, Sumatriptan 100 mg, temazepam 30 mg, Valtrex 1 g, vitamin B12, Zanaflex 4 mg, Zofran 8 mg and Zyprexa 20 mg. Urinary Drug Screen (UDS) dated 06/11/2013 revealed a negative toxicology screen but positive results for Alprazolam, Fentanyl, Fiorinal, Norco, and Temazepam. Toxicology report dated 02/16/2013 revealed hemoglobin 11.0 low; hematocrit 33.8 low; RDW 18.6 high; sodium serum 126 low; chloride, Serum 92 low; calcium serum 8.6 low; protein total serum 5.6 low; THS 4.94 high. Progress report dated 01/31/2014 reported the patient complained of low back pain and lumbar pain. She reported stiffness and condition worsens with flexion and extension. She rated her pain as a 4/10. On exam, motor strength is 5-/5 in all planes. On neuro exam, S1 and L5 dermatomes revealed decreased light touch sensation bilaterally. There is pain of the lumbosacral spine. There is positive FABER maneuver bilaterally; positive Patrick's maneuver bilaterally, positive pelvic rock maneuver bilaterally. She has pain to palpation over the L4 to L5 and L5 to S1 facet capsules bilaterally. Prior utilization review dated 02/18/2014 states the request for 1 prescription of Percocet 10/325 mg #240 has been modified to a certification of 1 prescription of Percocet 10/325 mg between 01/31/2014 and 04/11/2014. The request for a CBC, CMP, and UDA has been modified to 1 UDA between 01/31/2014 and 04/11/2014 The request for an evaluation with [REDACTED], 1 psych evaluation, Alprazolam, Fentanyl, Lunesta, Sumatriptan, Temazepam, Zanaflex, have been denied as there is no documented evidence of functional improvement, failure to respond on

limited course of opioids and most chronic pain medications are recommended for short term use only. The spinal cord stimulator is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 EVALUATION WITH ██████████ FOR SPINAL CORD STIMULATOR TRIAL:

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cords Stimulators (SCS). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators (SCS) Page(s): 105-107.

Decision rationale: The current medical documentation indicates that the patient is suffering from dependence issues and has been advised to enter inpatient detoxification. The guidelines indicate that a spinal cord stimulator is not recommended for patients with current evidence of substance abuse. Therefore the request is not medically necessary.

1 PSYCH EVALUATION: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluations Page(s): 100-101.

Decision rationale: The current medical documentation indicates that the patient is suffering from dependence issues and has been advised to enter inpatient detoxification. The guidelines indicate that a spinal cord stimulator is not recommended for patients with current evidence of substance abuse. Therefore, the request for psych evaluation (pre-stimulator) is also not medically necessary.

1 PRESCRIPTION OF ALPRAZOLAM 2MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: Alprazolam, Fentanyl, Lunesta, Sumatriptan, Temazepam, Zanaflex, have been denied as there is no documented evidence of functional improvement, failure to respond

on limited course of opioids and most chronic pain medications are recommended for short term use only.

1 PRESCRIPTION OF FENTANYL 100MCG/HR #15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic Page(s): 44.

Decision rationale: Fentanyl is not medically necessary as there is no documented evidence of functional improvement, failure to respond on limited course of opioids and most chronic pain medications are recommended for short term use only.

1 PRESCRIPTION OF PERCOCET 10/325 #240: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Percocet Page(s): 92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: Percocet is not medically necessary as there is no documented evidence of functional improvement, failure to respond on limited course of opioids and most chronic pain medications are recommended for short term use only.

1 PRESCRIPTION OF SUMATRIPTAN 100MG #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), Triptans.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head, Triptans.

Decision rationale: Sumatriptan is denied as there is no documented evidence of functional improvement, failure to respond on limited course.

1 PRESCRIPTION OF TEMAZEPAM 30MG #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, Benzodiazepines.

Decision rationale: Temazepam has been denied as there is no documented evidence of functional improvement and the medication is not recommended for long term use as the long term efficacy is unproven.

1 PRESCRIPTION OF ZANAFLEX 4MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-67. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: Zanaflex is denied as there is no documented evidence of functional improvement, failure to respond on limited course of opioids and most chronic pain medications are recommended for short term use only.

1 CBC, CMP AND UDS: 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: <http://www.nlm.nih.gov/medlineplus/ency/article/003642.htm>.

Decision rationale: The Guidelines recommend a patient be screened yearly. The supporting documentation does not indicate a recent screen has been performed. Therefore, the request is not medically necessary as it does not fall within the respective guidelines.