

<b>Case Number:</b>	CM14-0054705		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	08/18/2006
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	03/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/23/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 50- year-old individual was reportedly injured on August 18, 2006. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated January 14, 2014, indicated that there were ongoing complaints of low back pain. The physical examination demonstrated a 5'9," 244 pound individual who was hypertensive (145/91) and continues to have pain. A decrease lumbar spine range of motion was noted. There was tenderness to palpation along with muscle spasm. Sensory changes were noted in the bilateral L3, L4, L5, and S1 dermatomes. Diagnostic imaging studies objectified noted a fusion mass and hardware. Previous treatment included lumbar fusion surgery, fusion surgery hardware removal, and multiple pain management interventions (intrathecal pump). A request had been made for multiple medications and was not medically necessary in the pre-authorization process on March 27, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Drug Screening:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Indications for UDT.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43.

**Decision rationale:** A review of the records indicates the prior urine drug screenings did not identify all the medications that were being prescribed. As such, there is an indication of a drug diversions or inappropriate utilization therefore, the additional drug screening/urine toxicology is medically necessary.

**Oxycontin (dosage and amt unspecified):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74, 78, 93.

**Decision rationale:** The medical records and the handwritten progress notes do not outline the efficacy or utility for the date of this medication. Furthermore, one cannot ascertain the morphine equivalent dose (MED) when not being informed of the dosage and frequency therefore, based on the clinical information this request is not medically necessary.

**Norco (dosage and amt unspecified):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78.

**Decision rationale:** The medical records and the handwritten progress notes do not outline the efficacy or utility for the date of this medication. Furthermore, one cannot ascertain the morphine equivalent dose (MED) when not being informed of the dosage and frequency therefore, this request is not medically necessary.

**Gabapentine (dosage and amt unspecified):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-20, 49.

**Decision rationale:** This medication can be supported for the treatment of diabetic neuropathy or post-herpetic neuralgia. An off label use for neuropathic lesions has also been established. The lumbar fusion surgery and hardware are well documented. However, what is not documented is a clinical assessment of the efficacy and utility of this medication, therefore this request is not medically necessary.

**Tramadol (dosage and amt unspecified): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82, 113.

**Decision rationale:** When noting that this is a lumbar fusion situation with hardware and ongoing complaints of pain, there are indicators that there is a chronic pain issue. However, the progress notes do not demonstrate the efficacy or utility of this medication. There is no competent clinical assessment of the current condition to support the ongoing use of this medication. It is noted this is a "2nd line" intervention, and when noting other narcotic medications being prescribed and by the lack of a clinical assessment, there is insufficient information therefore, this request is not medically necessary.

**Naproxen (dosage and amt unspecified): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66 & 73.

**Decision rationale:** When noting the date of injury, the surgical interventions completed, the ongoing complaints, and the lack of any clinical information presented to support that this medication is having any positive effect whatsoever, there is very little clinical data to establish the medical necessity of this preparation therefore this request is not medically necessary.

**Zanaflex (dosage and amt unspecified): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 66.

**Decision rationale:** This medication is a centrally acting alpha-2 antiepileptic for the treatment of spasticity. While noting there are complaints of muscle spasm and low back pain, there is no indication of the spasticity that this medication is intended to treat, there is insufficient clinical information presented in the progress notes to support the ongoing use or determine therefore, this request is not medically necessary.

**Ambien (dosage and amt unspecified): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Chapter.

**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 updated August 2014.

**Decision rationale:** It is noted that neither the MTUS nor the ACOEM guidelines address this preparation. The parameters noted in the ODG were used. This is a short acting non-benzodiazepine hypnotic medication, which is for the short-term treatment of insomnia. The short-term is approximately 2 to 6 weeks. This is not indicated for chronic or indefinite use. When noting there is no narrative presented discussing the need for this medication, there is insufficient information therefore, this request is not medically necessary.



