

Case Number:	CM15-0000936		
Date Assigned:	01/12/2015	Date of Injury:	01/10/2001
Decision Date:	04/09/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	01/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Pennsylvania, Ohio, California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 injured worker is a 47-year-old male, who sustained an industrial injury on 1/10/2001. The diagnoses have included cervical sprain. Treatment to date has included magnetic resonance imaging (MRI) of the cervical spine dated 7/07/2014 revealed C4-5 degenerative disc disease with 1.5 mm central disc protrusion with annular tear indenting the cord 2.4mm in flexion and 1.5mm in extension. The C5/6 non-instrumental fusion with osseous graft disc, C6/7 probable non-instrumental fusion with fibular graft, subchondral fatty marrow changes, bilateral uncovertebral arthrosis producing neuro foraminal stenosis, postural changes, and metallic artifact within the upper nuchal ligament. Currently, the IW complains of constant neck pain radiating to the upper extremities with numbness and tingling rated as a 4-6/10 with medications and 8/10 without medications. Objective findings include decreased range of motion, and tender trapezius muscles and spasm bilaterally. On 12/17/2014, Utilization Review non-certified prescriptions for Somnicin #30, Trazodone 50mg #30, Lidoderm 5% patches #30, Sentra SM #60, and a qualitative urine drug screen and modified a prescription for Norco 10/325mg #180 noting the clinical findings do not support the medical necessity of the treatment. The MTUS, ACOEM and ODG were cited. On 1/05/2015, the injured worker submitted an application for IMR for review of Somnicin #30, Trazodone 50mg #30, Lidoderm 5% patches #30, Sentra SM #60, and a qualitative urine drug screen and modified a prescription for Norco 10/325mg #180.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prescription of Somnicin #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, Pain.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on drug testing, page 43, states that urine drug testing is recommended as an option to assess for the use or presence of illegal drugs. The medical records do not discuss risk factors for aberrant behavior. Moreover, a recommendation has been made at this time that continued opioid treatment is not medically necessary. Therefore, it follows that qualitative urine drug screening is not medically necessary. I note that specifically with regard to the retrospective timeframe of the requested urine drug screen of 11/11/2014, the records do not discuss risk factors for aberrant behavior or frequency of planned urine drug screening, and for that reason the urine drug screen is not medically necessary retrospectively. This drug screen is also not indicated prospectively, given that further opioid treatment has been deemed not medically necessary. Therefore, overall the request for a qualitative urine drug screen is not medically necessary.

Decision rationale: This medication is a medical food. The Medical Treatment Utilization Schedule does not discuss indications for medical foods. Official Disability Guidelines/Treatment in Workers Compensation/Pain does discuss medical food. Medical food is indicated only if there is documentation of a specific disease for which there are particular nutritional requirements. These criteria are not met in this case. This request is not medically necessary.

Prescription of Norco 10/325mg, #180: Upheld

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

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

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on opioids/ongoing management, page 78, discusses the 4 A's of opioid management in detail. The medical records in this case discuss only subjective reports of opioid effects. The records in this case do not clearly document the 4 A's of opioid management. A rationale or indication for ongoing opioid use is not apparent. This request is not medically necessary.

Prescription of Trazodone 50mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness & Stress.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 18th Edition (web), 2013, Treatment in Workers Compensation, Pain, Insomnia Treatment.

Decision rationale: The Medical Treatment Utilization Schedule does not directly discuss trazodone. This is an antidepressant, which is discussed in Official Disability Guidelines/ Treatment in Workers Compensation/Pain/Insomnia Treatment. This medication is indicated in some patients for management of insomnia if there is comorbid depression. The records do not document such comorbid depression, and the records contain very limited information regarding insomnia. Overall, the records do not support a rationale for this request. This request is not medically necessary.

Prescription of Lidoderm 5% patches, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch). Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics, Topical Lidoderm Page(s): 112.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on topical analgesics discusses topical Lidoderm on page 112. This medication is indicated only for localized peripheral neuropathic pain after there has been a trial of first-line therapy, including a tricyclic antidepressant or serotonin norepinephrine reuptake inhibitor antidepressant or antiepileptic drug. The medical records in this case do not clearly document the presence of localized peripheral neuropathic pain or failure of first-line neuropathic pain treatment. The records do not provide an alternate rationale for this request. This request is not medically necessary.

Sentra AM #60: 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 (Chronic) Medical Food.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 18th Edition (web), 2013, Treatment in Workers Compensation, Pain, Medical Food.

Decision rationale: This medication is a medical food. The Medical Treatment Utilization Schedule does not discuss indications for medical foods. Official Disability Guidelines/

Treatment in Workers Compensation/Pain does discuss medical food. Medical food is indicated only if there is documentation of a specific disease for which there are particular nutritional requirements. These criteria are not met in this case. This request is not medically necessary.

One Qualitative Urine Drug Screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Regarding Urine Drug Screens. Decision based on Non-MTUS Citation Official Disability Guidelines Criteria for use of Urine Drug Testing.

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

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on drug testing, page 43, states that urine drug testing is recommended as an option to assess for the use or presence of illegal drugs. The medical records do not discuss risk factors for aberrant behavior. Moreover, a recommendation has been made at this time that continued opioid treatment is not medically necessary. Therefore, it follows that qualitative urine drug screening is not medically necessary. I note that specifically with regard to the retrospective timeframe of the requested urine drug screen of 11/11/2014, the records do not discuss risk factors for aberrant behavior or frequency of planned urine drug screening and for that reason, the urine drug screen is not medically necessary retrospectively. This drug screen is also not indicated prospectively, given that further opioid treatment has been deemed not medically necessary. Therefore, overall the request for a qualitative urine drug screen is not medically necessary.