

Case Number:	CM15-0146082		
Date Assigned:	08/06/2015	Date of Injury:	04/01/1994
Decision Date:	09/21/2015	UR Denial Date:	07/17/2015
Priority:	Standard	Application Received:	07/27/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 60-year-old male, who sustained an industrial injury on April 1, 1994. Treatment to date has included cervical fusion with revision, lumbar discectomy, chiropractic therapy, opioid medication, physical therapy, TENS unit, cognitive behavioral therapy and biofeedback, home exercise program, epidural steroid injection and nerve blocks. Currently, the injured worker complains of pain in his neck, low back, bilateral wrist and headaches. He reports associated numbness, tingling and weakness of the bilateral upper extremities and the bilateral lower extremities. He notes that his pain is aggravated with cold, activity, rest, lying down, sitting, standing and walking. His pain is relieved with heat, activity, rest, lying down, walking, medication and massage. The injured worker reports no improvement in his pain since the previous evaluation and states that his low back pain radiates to his feet and he has associated numbness. He rates his pain an 8 on a 10-point scale without medications and a 5 on a 10-point scale with medications. The medications allow him to function, increase his mobility and perform activities of daily living and home exercises. His current medications include Duragesic patch, Roxicodone, Fiorinal, Lidoderm patch, Ativan, apap-isometheptene, and Cyclobenzaprine. On physical examination, the injured worker has tenderness to palpation over the cervical paraspinal muscles to the mid lower thoracic spine. His cervical spine range of motion is limited and he has a positive Spurling Maneuver. He has positive bilateral straight leg raise tests and limited lumbar range of motion. The injured worker exhibits an antalgic gait and has abnormal toe-heel walking. His bilateral upper extremity motor strength is within normal limits and he has decreased sensation to light touch at C6 and C7. The diagnoses associated with the request include headache, low back pain, thoracic-lumbosacral neuritis-radiculitis, cervical radiculopathy, cervicalgia, post laminectomy syndrome of the lumbar and cervical region,

lumbar degenerative disc disease, cervical degenerative disc disease, and degeneration of lumbar and cervical intervertebral discs. The treatment plan includes continued home exercise program, heath therapy, continued Roxicodone, fiorinal, lidoderm patches, Duragesic patches, urine drug screen, aqua therapy, psych evaluation and treatment, and consideration for spinal cord stimulator.

IMR ISSUES, DECISIONS AND RATIONALES

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

Roxicodone 15mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for roxicodone, California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function (in terms of specific examples of functional improvement) and no discussion regarding aberrant use. Furthermore, while the provider notes that no adverse effects are caused by the medication, another section of the same report notes that the patient wishes to discontinue roxicodone due to severe nausea. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested roxicodone is not medically necessary.

Duragesic 50mcg/hr #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl transdermal (Duragesic; generic available).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for Duragesic, California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function (in terms of specific examples of functional improvement) and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Duragesic is not medically necessary.

1 urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine drug screens. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic) - Urine drug testing (UDT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79 and 99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, and Urine Drug Testing.

Decision rationale: Regarding the request for a urine toxicology test (UDS), CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. Within the documentation available for review, there is no documentation of the date and results of prior testing and current risk stratification to identify the medical necessity of drug screening at the proposed frequency. In light of the above issues, the currently requested urine toxicology test is not medically necessary.

Fiorinal 50/325/40mg (unspecified quantity): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23 of 127.

Decision rationale: Regarding the request for Fiorinal, Chronic Pain Medical Treatment Guidelines state that barbiturate containing analgesic agents is not recommended for chronic pain. They go on to state that the potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. As such, the currently requested Fiorinal is not medically necessary.

Lidoderm 5% patches: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm - lidocaine patch.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112 of 127.

Decision rationale: Regarding request for Lidoderm, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the 1st line therapy such as tri-cyclic antidepressants, SNRIs, or antiepileptic drugs. Within the documentation available for review, there is no indication that the patient has localized peripheral neuropathic pain and failure of first-line therapy. As such, the currently requested Lidoderm is not medically necessary.

Unknown psych evaluation and treatment: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 100-102 of 127.

Decision rationale: Regarding the request for psych evaluation and treatment, Chronic Pain Medical Treatment Guidelines state that psychological evaluations are recommended. Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected using pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are pre-existing, aggravated by the current injury, or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. Within the documentation available for review, the provider noted that a psychiatrist previously saw the patient and there is no rationale presented for another evaluation. Furthermore, a nonspecific and open-ended request for treatment is not supported and, unfortunately, there is no provision for modification of the current request. In the absence of clarity regarding those issues, the currently requested psych evaluation and treatment is not medically necessary.