MAXIMUS Federal Services

Case Number:	CM15-0047457		
Date Assigned:	03/19/2015	Date of Injury:	03/06/2002
Decision Date:	05/01/2015	UR Denial Date:	03/04/2015
Priority:	Standard	Application Received:	03/12/2015

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: Texas, New York, California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 applicant is a represented [redacted] employee who has filed a claim for chronic neck, back, hip, and leg pain reportedly associated with an industrial injury of March 6, 2002. In a Utilization Review report dated March 4, 2015, the claims administrator partially approved a request for Norco, denied a request for urine drug testing, approved a request for Tramadol, denied a request for Ambien, denied a request for Fioricet, and partially approved a request for Neurontin. The claims administrator referenced an RFA form received on February 27, 2015 and an associated progress note of February 11, 2015 in its determination. The applicant's attorney subsequently appealed. On March 15, 2015, the applicant reported ongoing complaints of neck and low back pain, 4/10 with medications versus 8-9/10 without medications. The applicant was not working, it was acknowledged. The applicant was pending hip surgery on March 24, 2015, it was acknowledged. The applicant was asked to employ a topical compounded Flurbiprofen-containing cream. Ambien, Fioricet, and Neurontin were endorsed. In an earlier progress note dated February 4, 2015, the applicant was placed off of work, on total temporary disability. Authorization for a hip arthroscopy was sought. Highly variable 5-9/10 pain was reported about the neck, hip, and lower back, reportedly improved on medications and worsened by activities. The applicant was not working, it was acknowledged. On January 9, 2015, Norco, Ambien, Tramadol, Fioricet, and Neurontin were all renewed. The applicant was reportedly pending a spinal cord stimulator trial, it was stated on this occasion. The applicant was not working following the imposition of permanent work restrictions, it was further noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) urine drug screening: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43. Decision based on Non-MTUS Citation ODG Integrated Treatment/ Disability Duration Guidelines Pain (Chronic), Urine drug testing (UDT).

Decision rationale: No, the request for a urine drug screen was not medically necessary, medically appropriate, or indicated here. While page 43 of the MTUS Chronic Pain Medical Treatment Guidelines does support intermittent drug testing in the chronic pain population, the MTUS does not establish specific parameters for or identify a frequency with which to perform drug testing. ODG's Chronic Pain Chapter Urine Drug Testing topic, however, stipulates that an attending provider clearly state which drug tests and/or drug panels he intends to test for, attach an applicant's complete medication list to the Request for Authorization for testing, eschew confirmatory and/or quantitative testing outside of the Emergency Department drug overdose context, and attempt to conform to the best practices of the United States Department of Transportation when performing drug testing. In this case, however, it was not clearly stated which drug tests and/or drug panels were being tested for. It was not clearly stated when the applicant was last tested. The attending provider neither signaled his intention to eschew confirmatory testing nor signaled his intention to conform to the best practices of the United States Department of Transportation (DOT) here. Since several ODG criteria for pursuit of drug testing were not met, the request was not medically necessary

Norco 10/325 mg #120: 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 7) When to Continue Opioids Page(s): 80.

Decision rationale: Similarly, the request for Norco, a short-acting opioid, was not medically necessary, medically appropriate, or indicated here. As noted on page 80 of the MTUS Chronic Pain Medical Treatment Guidelines, the cardinal criteria for continuation of opioid therapy include evidence of successful return to work, improved functioning, and/or reduced pain achieved as a result of the same. Here, however, the applicant was off of work, it was acknowledged on multiple progress notes of late 2014 and early 2015, referenced above. The applicant continued to report pain complaints as high as 8-9/10 at times, despite ongoing Norco usage. The attending provider failed to outline any meaningful or material improvements in function effected as a result of ongoing Norco usage (if any). Therefore, the request was not medically necessary.

Ambien 10 mg #30 with 1 refill: 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: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Approach to Chronic Pain Management Page(s): 7-8. Decision based on Non-MTUS Citation U.S. Food and Drug Administration INDICATIONS AND USAGE. Ambien is indicated for the short-term treatment of insomnia characterized by difficulties with sleep initiation. Ambien has been shown to decrease sleep latency for up to 35 days in controlled clinical studies.

Decision rationale: Similarly, the request for Ambien, a sleep aid, was likewise not medically necessary, medically appropriate, or indicated here. As noted on pages 7 and 8 of the MTUS Chronic Pain Medical Treatment Guidelines, an attending provider using a drug for non-FDA labeled purposes has the responsibility to be well informed regarding usage of the same and should, furthermore, furnish compelling evidence to support such usage. The Food and Drug Administration (FDA) notes that Ambien is indicated in the short-term treatment of insomnia, for up to 35 days. Here, however, the request in question represents a renewal request for Ambien. The 30-tablet, one-refill supply of Ambien at issue, furthermore, in and of itself, represents treatment in excess of the FDA parameters. The attending provider failed to furnish a clear or compelling applicant-specific rationale for further treatment with Ambien beyond FDA parameters. Therefore, the request was not medically necessary.

Fiorcet 50/325/40 mg #30 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs) Page(s): 23.

Decision rationale: The request for Fioricet, a barbiturate-containing analgesic, was likewise not medically necessary, medically appropriate, or indicated here. As noted on page 23 of the MTUS Chronic Pain Medical Treatment Guidelines, barbiturate-containing analgesics such as Fioricet are not recommended in the chronic pain context present here owing to the potential for drug dependence. Here, the attending provider failed to furnish a clear or compelling applicant-specific rationale for selection of Fioricet in the face of the unfavorable MTUS position on the same. Therefore, the request was not medically necessary.

Neurontin 600 mg #60 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin, Gabarone TM, generic available) Page(s): 19.

Decision rationale: Finally, the request for Neurontin (gabapentin), an anticonvulsant adjuvant medication, was likewise not medically necessary, medically appropriate, or indicated here. As noted on page 19 of the MTUS Chronic Pain Medical Treatment Guidelines, applicants using gabapentin should be asked at each visit as to whether there have been improvements in pain and/or function affected as a result of the same. Here, however, the applicant was off of work, it was acknowledged on multiple progress notes of late 2014 and early 2015, referenced above. The applicant continued to report pain complaints as high as 8-9/10, despite ongoing usage of Neurontin. Ongoing usage of Neurontin failed to curtail the applicant's dependence on opioid agents such as Norco and barbiturate-containing analgesics such as Fioricet, it was noted on several progress notes, referenced above. The attending provider failed to outline any meaningful or material improvements in function effected as a result of ongoing Neurontin (gabapentin) usage, it is further noted. All of the foregoing, taken together, suggested a lack of functional improvement as defined in MTUS 9792.20f, despite ongoing Neurontin usage. Therefore, the request was not medically necessary.