

Case Number:	CM14-0160496		
Date Assigned:	10/06/2014	Date of Injury:	11/02/2012
Decision Date:	10/30/2014	UR Denial Date:	08/29/2014
Priority:	Standard	Application Received:	09/30/2014

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 Occupational Medicine 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:

According to the provided documents, this is a 50-year-old woman with an injury date on 11/2/12. A QME from 7/17/14 indicated that there is bilateral upper extremity pain and lower back. The mechanism of injury was lifting a package. She developed pain in the left arm, throughout the arm. The pain was mostly at the medial elbow. There was also a cumulative trauma mechanism described elsewhere. The patient has been treated conservatively with physical therapy, activity modification, and medications. She had a carpal tunnel release on the left on 1/17/14 that only gave minimal improvement. The patient originally presented with complaints of left arm pain about the elbow. Disputed requests are Tylenol #3, #120, diclofenac-lidocaine topical 180 g, Prilosec 20 mg #60 and UDS (urine drug screen). These are addressed in the utilization review determination letter from 8/29/14. Urine drug screens were collected on 1/6/14 (indicated tramadol was prescribed but not detected; codeine was also negative). There was a prescription invoice with a date of service from 1/1/14, for Tylenol #3, so it is likely the urine drug screen indication that the patient was taking tramadol was an error and that she was actually being prescribed Tylenol #3 at that time. A 1/27/14 PR-2 did not address the urine drug screen results. Another urine drug test was ordered that date, and she was given a refill of Tylenol #3. Left carpal tunnel release was done on 1/17/14, and there was subsequent postoperative physical therapy. There was a urine drug screen collected on 5/20/14 which indicated that codeine was prescribed but not detected. A 6/30/14 PR-2 made no mention of the urine drug test results and again the patient was prescribed Tylenol #3, #90. There is indication in the medical records that the patient had been prescribed Prilosec along with an oral nonsteroidal anti-inflammatory since sometime in 2013 and the aforementioned 1/17/14 report indicated patient was prescribed naproxen, Prilosec, as well as a topical compound at that time. None of the reports after the carpal tunnel release mentioned continued use of the naproxen or

any other nonsteroidal anti-inflammatory medication but omeprazole is continued. Patient was given different topical compounds at various times. The PR-2 from 8/10/14 is the 1st to mention a prescription of the topical diclofenac/lidocaine (3%/5%) 180 g. This is a cream or ointment. The report states this is given in an attempt to decrease her Tylenol #3 intake. Patient was also given refills of the Tylenol #3 and the Prilosec. Most of the previous fills of Tylenol #3 had been for #90 but this quantity was #120, with no mention of why the quantity was increased. Patient continued to complain of pain at the same high levels as she had on all of the previous reports. Levels were 8-9/10. Reportedly using the Tylenol #3 brought her pain down from a 9 to a 4. The Prilosec helps her gastrointestinal issues. There is no mention of actual average daily number of Tylenol #3 that the patient uses nor is there any mention as to whether or not she had any left over from previous prescriptions. Urine toxicology screen was requested for the next visit. The patient was on a modified work status but there is no mention that she was actually working.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tylenol #3, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines part 2 Page(s): 38,74-96.

Decision rationale: Tylenol #3 is a combination of acetaminophen and codeine, a short acting opioid analgesic. This medication has been prescribed since at least January 2014. During that time the patient underwent carpal tunnel surgery, had continued physical therapy and required ongoing monthly follow-ups with prescription of the Tylenol #3 each visit as well as a variety of topical creams and omeprazole. Although there is reported subjective improvement in pain with use of the medication, there was no documentation of any objective functional benefits derived from use of the opioid, no progress towards returning to regular work or any reduction in need for medical treatment. Furthermore, the patient had at least 2 urine drug screens during that time that were negative for the medication and thus it is clear that she is not using this around-the-clock or on a regular everyday basis. Despite this, and despite no mention of any questioning of the patient about the number of pills she was taking she was prescribed it again every month. The current request was actually for #120 without any indication as to why the quantity should be increased. Management of opiates per MTUS guidelines should include the lowest possible dose to improve pain and function. There should be ongoing monitoring of pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant or nonadherent drug behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drugtaking behaviors). There is no documentation of these factors to support the medical necessity for ongoing use of the opiate. MTUS guidelines also state that opiates should be discontinued when there is no overall improvement in function which is also not documented in the reports. Thus, taking into consideration the evidence and the guidelines the continued use of Tylenol #3 is not medically

necessary. Note is made that abrupt cessation could be harmful and a plan for a taper and wean would be appropriate.

Diclofenac-Lidocaine topical 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2 Page(s): 111-113.

Decision rationale: MTUS guidelines only support use of topical lidocaine in the patch formulation. This is in combination with a nonsteroidal anti-inflammatory (diclofenac) plus the lidocaine being dispensed in grams which indicates that this is not in a patch formulation. There is no rationale provided for why this patient would require this topical this good asleep preparation combination instead of a lidocaine patch. Therefore, based upon the evidence and the guidelines, this is not considered to be medically necessary.

Prilosec 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines part 2 Page(s): 68.

Decision rationale: This patient has not used a nonsteroidal anti-inflammatory medication for over 6 months. MTUS guidelines only support use of a proton pump inhibitor such as omeprazole when there are increased risk factors for gastrointestinal side effects. The patient is less than 65. There is no history of peptic ulcer, GI bleeding or perforation. There is no concurrent use of ASA, corticosteroids, and/or an anticoagulant. There is no use of high dose/multiple NSAID. There is no mention of any gastrointestinal illnesses that would require treatment. Therefore there is no medical necessity for this medication based upon the evidence the guidelines.

Urine drug screen: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Urine Drug Testing

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2, opioids Page(s): 77-80,89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG ODG pain, (chronic) urine drug testing)

Decision rationale: The MTUS recommends using a urine drug screen to assess for the use or the presence of illegal drugs, a step to take before a therapeutic trial of opioids, to aid in the ongoing management of opioids, or to detect dependence and addiction. This patient has been prescribed an opiate, codeine, but she has had two urine drug tests in the last 6 months that did not detect it and the follow-ups after those urine drug screens when results were available made no mention of the negative results, no mention of any discussion with the patient about how often she uses it or what her compliance was. Urine drug screens are therefore clearly not being used to monitor the opiate use or manage the opiate use. There is no mention of any concern for drug abuse/misuse, addiction or dependence. MTUS guidelines do not specifically address what type of specific testing is to be used for urine drug testing to be done but ODG goes into more details regarding the protocols and type of testing. In this case, the type of urine drug test being done was exclusively by use of GC/MS which per ODG guidelines should only be used for confirmatory testing when unexpected positives or negatives need to be confirmed following initial screening testing. There is no indication that any initial screening tests are being done. Therefore based upon the evidence and the guidelines, this request was not considered to be medically necessary.