

Case Number:	CM15-0013314		
Date Assigned:	01/30/2015	Date of Injury:	09/07/2006
Decision Date:	03/27/2015	UR Denial Date:	01/12/2015
Priority:	Standard	Application Received:	01/22/2015

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

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 57 year old female sustained an industrial injury on 9/7/06. She subsequently reports chronic low back pain. Diagnostic studies include various x-rays, CT scans and MRIs. The injured worker has undergone lumbar fusion surgeries, had a spinal cord stimulator implanted. Current medications include Gabapentin and Norco. The UR decision dated 1/12/15 non-certified 1. Retrospective Review-Urine Drug Screen (DOS 12-11-14); 2. Prospective usage of Soma 350MG #120 With 1 Refill; 3. Prospective Usage of Dilaudid 4MG #90; 4. Prospective Usage of Norco 10/325MG #180. The 1. Retrospective Review-Urine Drug Screen (DOS 12-11-14); 2. Prospective usage of Soma 350MG #120 With 1 Refill; 3. Prospective Usage of Dilaudid 4MG #90; 4. Prospective Usage of Norco 10/325MG #180 denials were based on CA MTUS and ODG guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Review of Urine Drug Screen (DOS 12/11/2014): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Procedure Summary

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

Decision rationale: According to the 1/12/15 Utilization Review letter, the urine drug screen on 12/11/14 was denied because the patient had a urine drug screen the day before on 12/10/14 and the reviewer said the necessity of testing two days in a row is not established, but then the reviewer sees the first drug test was inconsistent, showing non-prescribed medications, and then modifies the 12/11/14 drug screen to allow a 10-panel urine drug screen for qualitative analysis. According to the 12/10/14 physiatry report, the patient presents with 10/10 low back pain that radiates to the right hip and down the right leg. The medications bring the pain to 7/10. The patient is scheduled for spinal surgery on 12/18/14, but she was fearful because she received a notice that the medications will not be provided in mid-December and she is fearful she will undergo surgery and not be provided with medication to control pain afterwards. Her diagnoses include: status post lumbar fusion times two L3-S1; s/p hardware removal June 2010; Arachnoiditis; chronic right lower extremity radiculopathy; Failed back syndrome; cervical myospasms with right upper extremity radiculitis; intractable pain syndrome; facet arthropathy L3/4 and L5/S1 causing right lateral recess stenosis; s/p failed spinal cord stimulator trial October 2012; and possible non union at L3/4. MTUS Chronic Pain Medical Treatment Guidelines, for Drug Testing, pg 43 under Drug testing states: Recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs The available medical reports from 4/14/14 through 1/2/15 do not discuss results or frequency of any urine drug tests. MTUS guidelines allows for urine drug screens to assess for presence of illegal drugs. Based on the available information, the request appears to be in accordance with the MTUS guidelines. The request for Retrospective review of urine drug screen (DOS:12/11/2014) IS medically necessary.

Soma 350mg, #120 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants; Carisoprodol (Soma) Page(s): 63-66, 29.

Decision rationale: The 1/12/15 Utilization Review letter states the Soma requested on the 12/10/14 medical report was denied because it is not recommended for long-term use. The provided records show the patient has been using Soma since 4/14/15. The 12/10/14 medical report states the patient takes Soma 350mg, q6 hours as needed for spasms. She was prescribed Soma 350mg, #120 with 1 refill. MTUS Chronic Pain Medical Treatment Guidelines, page 29 for Carisoprodol (Soma) states: Not recommended. This medication is not indicated for long-term use. MTUS Chronic Pain Medical Treatment Guidelines, page 63-66, for Muscle relaxants (for pain), under Carisoprodol (Soma, Soprodal 350, Vanadom, generic available) states: Neither of these formulations is recommended for longer than a 2 to 3 week period. The provided records show the patient has used Soma over a 3-week period, which is not in accordance with MTUS

guidelines. The request for continued use of Soma 350mg, #120 with 1 refill IS NOT medically necessary.

Dilaudid 4mg, #90: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: The 1/12/15 Utilization Review letter states the Dilaudid 4mg requested on the 12/10/14 medical report was denied because there was no objective functional benefit and no indication the patient had the lumbar surgery. According to the 12/10/14 physiatry report, the patient presents with 10/10 low back pain that radiates to the right hip and down the right leg. The medications bring the pain to 7/10. The patient is scheduled for spinal surgery on 12/18/14, but she was fearful because she received a notice that the medications will not be provided in mid-December and she is fearful she will undergo surgery and not be provided with medication to control pain afterwards. Her diagnoses include: status post lumbar fusion times two L3-S1; s/p hardware removal June 2010; Arachnoiditis; chronic right lower extremity radiculopathy; Failed back syndrome; cervical myospasms with right upper extremity radiculitis; intractable pain syndrome; facet arthropathy L3/4 and L5/S1 causing right lateral recess stenosis; s/p failed spinal cord stimulator trial October 2012; and possible non union at L3/4. The physician states the patient has improved function with medications and that without them she would have difficulty tolerating even routine activities of daily living. There are no side effects and not aberrant drug behaviors. MTUS Chronic Pain Medical Treatment Guidelines, page 88-89 CRITERIA FOR USE OF OPIOIDS for Long-term Users of Opioids (6-months or more) states: Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument. MTUS states a satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The available records show the patient has 10/10 pain without medications and 7/10 with medications, and is anticipating lumbar surgical intervention. The physician reports improved function with ADLs with the medications that the patient would not be able to tolerate without medications. The physician reports a satisfactory response with use of Dilaudid. The request appears to be in accordance with MTUS guidelines. The request for Dilaudid 4mg, #90 IS medically necessary.

Norco 10/325mg, #180: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: The 1/12/15 Utilization Review letter states the Norco 10/325 mg, #180 requested on the 12/10/14 medical report was denied because there was no objective functional benefit and no indication the patient had the lumbar surgery. According to the 12/10/14 physiatry report, the patient presents with 10/10 low back pain that radiates to the right hip and down the right leg. The medications bring the pain to 7/10. The patient is scheduled for spinal surgery on 12/18/14, but she was fearful because she received a notice that the medications will not be provided in mid-December and she is fearful she will undergo surgery and not be provided with medication to control pain afterwards. Her diagnoses include: status post lumbar fusion times two L3-S1; s/p hardware removal June 2010; Arachnoiditis; chronic right lower extremity radiculopathy; Failed back syndrome; cervical myospasms with right upper extremity radiculitis; intractable pain syndrome; facet arthropathy L3/4 and L5/S1 causing right lateral recess stenosis; s/p failed spinal cord stimulator trial October 2012; and possible non union at L3/4. The physician states the patient has improved function with medications and that without them she would have difficulty tolerating even routine activities of daily living. There are no side effects and not aberrant drug behaviors. MTUS Chronic Pain Medical Treatment Guidelines, page 88-89 CRITERIA FOR USE OF OPIOIDS for Long-term Users of Opioids (6-months or more) states: Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument. MTUS states a satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The available records show the patient has 10/10 pain without medications and 7/10 with medications, and is anticipating lumbar surgical intervention. The physician reports improved function with ADLs with the medications that the patient would not be able to tolerate without medications. The physician reports a satisfactory response with use of Dilaudid and Norco. The request appears to be in accordance with MTUS guidelines. The request for Norco 10/325 mg, #180 IS medically necessary.