

Case Number:	CM15-0036287		
Date Assigned:	03/04/2015	Date of Injury:	03/26/2008
Decision Date:	06/08/2015	UR Denial Date:	02/17/2015
Priority:	Standard	Application Received:	02/26/2015

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: New York
 Certification(s)/Specialty: Pediatrics, Internal 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 injured worker is a 63-year-old male, who sustained an industrial injury on 3/26/2008. The diagnoses have included lumbar disc displacement without myelopathy. Treatment to date has included trigger point injections, medications self-directed physiotherapy, [REDACTED] program, acupuncture and intra-articular knee injection. He is status post spinal fusion at L3-4 (2011). Currently, the IW complains of back pain with radiation to the bilateral lower extremities. Objective findings included tenderness to palpation of the posterior lumbar musculature with numerous palpable trigger points. There is decreased range of motion. There is decreased range of motion of the right hip with minimal tenderness to palpation, Sensory examination shows decreased sensation of the lateral thigh and lateral calf on the left in comparison to the right. On 2/17/2015, Utilization Review non-certified a retrospective request (DOS 2/09/2015) for 1 urine drug test, Flexeril 10mg, Zofran 4mg, AndroGel 1.62% and Restoril 30mg noting that the clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The MTUS and ODG were cited. On 2/26/2015, the injured worker submitted an application for IMR for review of one urine drug test, Flexeril 10mg, Zofran 4mg, AndroGel 1.62% and Restoril 30mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Urine Drug Test: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates, steps to avoid misuse/addiction; Substance abuse (tolerance, dependence, addiction); Urine Drug Testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, pain treatment agreement Page(s): 89.

Decision rationale: According to MTUS guidelines, IW's treated with opioids may be required to sign a pain treatment agreement. Part of the agreement may include urine screening for medication and illicit substances. No pain management agreement was submitted stating urinalysis was required and there was no notation of irregular behavior suggesting abuse. Therefore, the request is not medically necessary and appropriate.

Retrospective prescription for Flexeril 10mg: 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).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-65.

Decision rationale: Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. The greatest effect appears to be in the first 4 days of treatment. The documentation does reference muscle spasm that the Flexeril would be used for however at this time frame it is not indicated. Therefore, the request is not medically necessary and appropriate

Retrospective prescription for Zofran 4mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Ondansetron; Antiemetics.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Antiemetics (for opioid nausea).

Decision rationale: MTUS does not comment on the use of antiemetics in chronic pain. ODG guidelines state that antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. Recommended for acute use as noted below per FDA-approved indications. Zofran is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. As the IW is not receiving chemotherapy or radiation this request is not medically necessary and appropriate.

Retrospective prescription for Androgel 1.62%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Testosterone replacement for hypogonadism.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Testosterone replacement for hypogonadism (related to opioids) Page(s): 110-111.

Decision rationale: MTUS guidelines recommend testosterone replacement in limited circumstances for patients taking high-dose long-term opioids with documented low testosterone levels. If needed, testosterone replacement should be done by a physician with special knowledge in this field given the potential side effects. The documentation does show that the IW had low testosterone levels however; his urologist stopped prescribing the testosterone due to prostatic concerns. Therefore, the request is not medically necessary and appropriate.

Retrospective prescription for Restoril 30mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Insomnia Treatment; Pain (Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Insomnia Treatment.

Decision rationale: Per ODG, pharmacological agents for insomnia should only be used after careful evaluation of potential causes of sleep disturbance for the etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). First-line treatment is recommended to be non-benzodiazepine sedative-hypnotics such as Ambien, Ambien CR, Sonata and Lunesta. Sedating antidepressants (e.g., amitriptyline, trazodone, mirtazapine) have also been used to treat insomnia; however, there is less evidence to support their use for insomnia, but they may be an option in patients with coexisting depression. There was no mention in the case file of evaluation for insomnia or failure of first line treatment options. Therefore, the request is not medically necessary and appropriate.