

Independent Medical Review Final Determination Letter

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Dated: 12/31/2013

IMR Case Number:	CM13-0024757	Date of Injury:	01/30/1999
Claims Number:	[REDACTED]	UR Denial Date:	08/19/2013
Priority:	STANDARD	Application Received:	09/16/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED] MD		
Treatment(s) in Dispute Listed on IMR Application:			
FENTANYL PATCH 50MCG#60, CARISOPRODOL 350MG #60, NORCO 10/325MG #120 LIDODEM PATCH 5%#30 NIGHT JOINT INJECTION PAIN PSYCHOLOGY CONSULT			

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal 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 physician 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.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

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

The patient is a 50-year-old female who reported an injury on 01/30/1999. The patient was noted to have a VAS of 7/10 with low back pain. The patient was noted to have bilateral Posterior Superior Iliac Spine (PSIS) spasms, left greater than right. The diagnosis were stated to include Chronic Low Back Pain, Bilateral Sacroilitis and Greater Trochanter Bursitis. The treatment plan was noted to include fentanyl patch 50 mcg #60, Carisoprodol 350 mg #60, Norco 10/325 mg #120, Lidoderm patch 5% #30, a right SI joint injection, and a pain psychology consultation.

IMR DECISION(S) AND RATIONALE(S)

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

1. Fentanyl patch 50mcg #60 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Duragesic, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Fentanyl Transdermal, page 93, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The CA MTUS Guidelines recommend fentanyl transdermal patches for patients who have moderate to severe pain requiring around the clock opioid therapy that cannot be managed by other means and it is for patients who are currently on opioid therapy for which a tolerance has developed. The clinical documentation submitted for review dated 10/04/2013 revealed the patient had a VAS of 6/10. The patient was noted to have PSIS tenderness on the right and was noted to have spasms on the left. The patient's medications were noted to be reordered. The note dated 09/06/2013 revealed the patient's pain was a 5/10 and pain was tolerable with the

medications. The patient was noted to have mostly low back pain. The clinical documentation submitted for review, while indicating the patient had pain levels ranging from 5/10 to 7/10, failed to provide the efficacy of the requested medication and additionally failed to indicate the patient had pain that could not be managed by other means, and that the patient was on opioid therapy for which a tolerance had developed. Given the above, the request for fentanyl patch 50 mcg #60 is not medically necessary.

2. Carisoprodol 350mcg #60 is not medically necessary and appropriate.

The Claims Administrator based its decision on the [Chronic Pain Medical Treatment Guidelines, Carisoprodol, which is part of the MTUS and the Official Disability Guidelines (ODG), which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Carisoprodol, page 29, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The CA MTUS Guidelines do not recommend long-term use of Carisoprodol for muscle spasms. The clinical documentation submitted for review dated 10/04/2013 revealed the patient had a VAS of 6/10. The patient was noted to have PSIS tenderness on the right and was noted to have spasms on the left. The clinical documentation submitted for review indicated that the patient had been taking the medication and had multiple refills; however, it failed to provide the efficacy of the requested medication although it was noted that the patient's pain was tolerable with the medications. Given the above, the request for Carisoprodol 350 mg #60 is not medically necessary.

3. Norco 10/325mg #120 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Opioids, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Norco, page 75, On-Going Management, page 78, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The CA MTUS Guidelines recommend Norco for chronic pain and it recommends that there should be documentation of the patient's analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. The clinical documentation submitted for review dated 10/04/2013 revealed the patient had a VAS of 6/10. The patient was noted to have PSIS tenderness on the right and was noted to have spasms on the left. The clinical documentation submitted for review indicated the patient stated the pain was tolerable with the medications; however, it failed to provide the patient's level of analgesia prior to and post medication, failed to provide the patient had an improvement in activities of daily living, failed to provide the patient had documentation of adverse side effects, and failed to provide documentation of aberrant drug taking behaviors. Given the above, the request for Norco 10/325 mg #120 is not medically necessary.

4. Lidoderm patch 5% #30 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Lidoderm, page 56, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The CA MTUS Guidelines recommend Lidoderm as a treatment for post herpetic neuralgia and it indicates that further research is needed to recommend this treatment for chronic neuropathic pain. The clinical documentation submitted for review dated 10/04/2013 revealed the patient had a VAS of 6/10. The patient was noted to have PSIS tenderness on the right and was noted to have spasms on the left. The clinical documentation submitted for review, while indicating the patient had efficacy of the group of medications, failed to provide the efficacy of the requested medication. Additionally, it was noted that the patient was on a fentanyl patch and a Lidoderm patch and it failed to provide the necessity for 2 patches for pain. Additionally, it failed to provide exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for Lidoderm patch 5% #30 is not medically necessary.

5. Right Sacroiliac (SI) joint injection is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Hip and Pelvis Chapter, which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), Low Back Chapter, Sacroiliac Joint Injections.

The Physician Reviewer's decision rationale:

The CA MTUS/ACOEM Guidelines do not specifically address sacroiliac joint injections. Official Disability Guidelines recommend sacroiliac joint injections if the patient has failed at least 4 to 6 weeks of aggressive conservative therapy. The clinical documentation submitted for review dated 10/04/2013 revealed the patient had a VAS of 6/10. The patient was noted to have PSIS tenderness on the right and was noted to have spasms on the left. The clinical documentation submitted for review failed to provide documentation that the patient had at least 4 to 6 weeks of aggressive conservative therapy and it failed to provide exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for right SI joint injection is not medically necessary.

6. Psychological pain consultation is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Psychological Evaluations, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Psychological Evaluations, page 100, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The CA MTUS Guidelines recommend psychological evaluations to determine if further psychosocial interventions are indicated. The clinical documentation submitted for review failed to provide the patient had documented subjective signs or symptoms to necessitate a pain psychology consultation. Given the above, the request for pain psychology consultation is not medically necessary.

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

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