MAXIMUS Federal Services

Case Number:	CM14-0001918		
Date Assigned:	01/24/2014	Date of Injury:	10/17/2002
Decision Date:	07/15/2014	UR Denial Date:	12/06/2013
Priority:	Standard	Application Received:	01/06/2014

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 Orthopedic Surgery, has a subspecialty in Shoulder and Elbow Surgery and is licensed to practice 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:

The injured worker is a 65-year-old female who reported an injury on 10/17/2002. The mechanism of injury involved a fall. Current diagnoses include lumbar strain with right lumbar radiculopathy, cervical strain, status post cervical fusion on 10/17/2003, status post right hip surgery on 01/06/2006, left hip pain, left knee strain, right shoulder strain with impingement, status post right shoulder surgery on 10/06/2008, left shoulder strain, status post left shoulder arthroscopic surgery on 03/16/2009, secondary depression, cervicogenic headaches, and unrelated fracture of the right femur. The injured worker was evaluated on 11/13/2013. The injured worker reported increasing pain in the lower back and right hip. Physical examination revealed moderate spasm in the lumbar spine with moderately decreased range of motion, tenderness with spasm in the paracervical muscles, decreased cervical range of motion, moderate tenderness in the right hip and groin area, moderately limited range of motion in the right hip, swelling in the left knee, limited range of motion of the left knee, and tenderness to palpation of the AC joint region bilaterally. Treatment recommendations at that time included authorization for a pain management consultation, a home health care assistant, and continuation of current medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

CONSULTATION-PAIN MANAGEMENT: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, , 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-90.

Decision rationale: The ACOEM guidelines state that a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. Based upon review of the documentation provided, the injured worker is on multiple high doses of medications and a consultation with a pain management specialist would be appropriate to determine the most appropriate treatment for the injured worker. Therefore, the requested consultation with pain management is medically necessary.

HOME HEALTH CARE ASSISTANT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Care Page(s): 51.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that home health care services are recommended for otherwise recommended medical treatment for patients who are homebound on a part time or intermittent basis. There is no indication that this injured worker is homebound and does not maintain assistance from outside resources. The total duration of treatment and specific services required were not listed in the request. Therefore, the request for a home health care assistant is not medically necessary.

MORPHINE SULFATE EXTENDED RELEASE 15 MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has utilized morphine sulfate since 05/2012. The injured worker continues to report increasing pain. There is no documentation of objective functional improvement. There is also no frequency listed in the current request. Therefore, the request for Morphine Sulfate Extended Release 15mg #60 is not medically necessary.

NORCO 10/325 MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has utilized Norco 10/325 mg since 09/2012. The injured worker continues to report increasing pain. There is no evidence of objective functional improvement. There is also no frequency listed in the current request. Therefore, the request for Norco 10/325mg #120 is not medically necessary.

MEDROX CREAM 120 GM: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. There is also no frequency listed in the current request. Therefore, the request for Medrox Cream 120gm is not medically necessary.

THERMACARE HEAT PATCHES #60: 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 ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: The ACOEM guidelines state that at-home local applications of heat or cold are as effective as those performed by a therapist. The injured worker has utilized a ThermaCare heat wrap since 09/2012. There is no documentation of objective functional improvement. There is no mention of a contraindication to at-home local applications of heat packs as opposed to a ThermaCare heat patch. Therefore, the request for ThermaCare Heat Patches #60 is not medically necessary.

SKELAXIN 800 MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations. Efficacy appears to diminish over time and prolonged use of some medications in this class may lead to dependence. The injured worker has utilized Skelaxin 800 mg since 09/2012. The injured worker continues to report increasing pain. Physical examination continues to reveal palpable muscle spasm. There is also no frequency listed in the current request. Therefore, the request for Skelaxin 800mg #60 is not medically necessary.