

<b>Case Number:</b>	CM14-0020405		
<b>Date Assigned:</b>	04/25/2014	<b>Date of Injury:</b>	08/31/2007
<b>Decision Date:</b>	07/09/2014	<b>UR Denial Date:</b>	01/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/18/2014

### 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 Neurology, has a subspecialty in Neuromuscular 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:

██████████ is a 53 year old man who sustained a work-related injury on August 31, 2007. Subsequently he developed chronic back pain and major depression. He underwent a back surgery on November 19 2009 and the patient was felt to reach maximum improvement on August 11 2010. According to a psychologist follow-up on January 16, 2014. The patient was in a pain with feeling of helpless and suicidal ideation. The patient was evaluated and admitted to an outside watch. Subsequently, the patient's condition improved. His examination performed on January 20, 2014, the patient was considered to be partially desable from his psychiatry condition. According to a progress note dated on April 9, 2014, the provider reported the patient is optimistic and able to return to water therapy. He was continued on Effexor, Klonopin, Deplin and Ambien. According to another progress note dated on March 24 2014, the patient was reported to have low back pain. His pain was described as a dull and sharp shooting pain. His physical examination showed lumbar tenderness with reduced range of motion. His neurological examination was not focal. He was diagnosed with meralgia parasthetica, lumbar radiculopathy, bilateral sciatica, lumbar facet arthropathy and post lumbar laminectomy syndrome . The patient was taking Opana and Lyrica in addition to the medications mentioned above. The medications were taken for long time, however the exact duration was not clear. Previously, he was treated with water therapy, lumbar nerve blocks and radiofrequency ablation on 2010, 2011 and 2012. He also underwent another lumbosacral radiofrequency ablation on 2013 followed by another .epidural injection. The patient was treated with behavioral therapy for probably 16 visits with substantial improvement. He has an MRI of the lumbar spine performed on June 10 2013 which showed status post L4-L5 pedicle screw fusion, April the patient left paracentral left sacral L5-S1 disc protrusion. In summary, the patient was diagnosed with with meralgia parasthetica, lumbar radiculopathy, bilateral sciatica, lumbar facet

arthropathy, post lumbar laminectomy syndrome, anxiety and depression. The provider requested treatment with psychological therapy sessions, Aquatherapy and Opana.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **PSYCHOLOGICAL THERAPY SESSIONS, #12: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cognitive Behavioral Therapy (CBT).

**Decision rationale:** According to ODG guidelines, psychotherapy is recommended Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See Fear-avoidance beliefs questionnaire (FABQ). Initial therapy for these "at risk" patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from physical medicine alone:- Initial trial of 3-4 psychotherapy visits over 2 weeks- With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions).The patient was diagnosed with anxiety and major depression which are risk factors for delaying his recovery. The need for psychotherapy session is established. He already has significant benefit from previous sessions. However the prescription of 12 sessions of psychotherapy is not necessary without documentation of pain and functional benefit. As per ODG guidelines, it is recommended to start with 6 sessions to monitor the patients' improvement for the need of more sessions. Therefore, the request for Psychological Therapy Sessions, #12 is not medically necessary.

#### **AQUA THERAPY SESSIONS, #12: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

**Decision rationale:** According to MTUS guidelines, aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. For recommendations on the number of supervised visits, see Physical medicine. Water exercise improved some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities maybe required to preserve most of these gains. (Tomas-Carus, 2007). There no clear evidence that the patient is

obese or need have difficulty performing land based physical therapy or the need for the reduction of weight bearing to improve the patient ability to perform particular exercise regimen. There is no documentation of functional benefit from previous aquatic therapy sessions. There is no clear objective documentation for the need of aquatic therapy. Therefore the prescription of AQUA THERAPY SESSIONS, #12 is not medically necessary.

**OPANA 10MG, #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-79.

**Decision rationale:** According to MTUS guidelines, Opana is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules:(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. There is no clear evidence of objective and recent functional and pain improvement with previous use of Opana. There no clear documentation of the efficacy/safety of previous use of Opana. There is no clear justification for the need to continue the use of Opana. Therefore, the prescription of Opana is not medically necessary at this time.

**OPANA ER 20MG, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-79.

**Decision rationale:** According to MTUS guidelines, Opana is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules:(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. There is no clear evidence of objective and recent functional and pain improvement with previous use of Opana. There no clear documentation of the efficacy/safety of previous use of Opana. There is no clear justification for the need to continue the use of Opana. Therefore, the prescription of OPANA ER 20MG, #60 is not medically necessary at this time.