

Case Number:	CM14-0064593		
Date Assigned:	07/11/2014	Date of Injury:	06/11/1991
Decision Date:	09/12/2014	UR Denial Date:	04/23/2014
Priority:	Standard	Application Received:	05/07/2014

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 Occupational 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:

The claimant injured her cervical and lumbar spines on 06/11/91. Norco, a urine drug screen, follow up with a spine surgeon, physical therapy for 12 visits, and a home health assistant for 6 months have been recommended and are under review. She is status post lumbar spine fusion surgery in 2011 and additional surgery in 2012 and has postlaminectomy syndrome and chronic pain. She has been diagnosed with cervical and lumbar radiculopathy. She has had Physical Therapy, Injections, and Medications including chronic opioid use. X-rays dated 12/09/13 revealed fusion with exaggerated lordosis and slight anterolisthesis of L4 with respect to L5. There was marked osteopenia. There was bone graft formation. There was a fusion at L5-S1. She saw [REDACTED] on 02/10/14. She had seen a spine surgeon [REDACTED] on 01/06/14 who recommended that she continue gait training classes. She was to follow-up with a Urologist. Spinal Surgeon Evaluation and follow-up were recommended. She saw [REDACTED] on 03/10/14 and her neck pain had resolved. Her left shoulder to arm pain was 7/10 and she had worsening low back symptoms rated 8-10/10. She had trouble walking and her legs were very weak. She had sharp burning, electrical pain and spasms from the vaginal and rectal areas down the sides of her legs to the foot. There were no physical exam findings. She walked very slowly and her legs felt very weak. She had sharp burning electrical pain and spasms. She was given Norco, and a urine toxicology screen and follow-up with spine surgeon [REDACTED] were requested. She also was to see the urologist, physical therapy was ordered, and home health care was recommended 4 days per week, 8 hours per day for 6 months. A drug screen dated 03/10/14 was positive for Hydrocodone and Hydromorphone and was consistent. On 04/14/14, she saw [REDACTED] and had severe mechanical back pain with left leg radiculopathies and severe electrical sensations and very marked numbness throughout the back.

She had mildly decreased strength primarily on the left side. Her imaging studies were reviewed. A CT scan was recommended to rule out persistent nerve compression. A spinal cord stimulator trial, Neurontin, and Norco were ordered. On 05/12/14, [REDACTED] recommended a CT scan of the lumbar spine and a trial of a spinal cord stimulator. On 05/13/14, [REDACTED], pain management, recommended a lumbar spine MRI and to continue home exercises and her medications. She was taking Percocet, Cymbalta, and Neurontin. A trial of spinal cord stimulator was under consideration. The Cymbalta was discontinued. She saw a urologist, [REDACTED] on 05/19/14. She had urologic problems that included cystocele, hypermobility of the urethra, a urethral carbuncle and uterine prolapse and they were nonindustrial. She was a candidate for bladder surgery. Studies were recommended. On 05/27/14, [REDACTED] recommended discontinuing Cymbalta due to allergy (itching). A CT scan was ordered. There were other urological and gynecological problems. She had continued constant low back pain and bilateral leg weakness. She was using a walker. Her right leg was giving out. She had continued anxiety and depression and very little sleep. On 06/19/14, she had low back pain that was constant and went down both legs with weakness. Her right leg would give 0 Give Way. She was walker-dependent. Lumbar spine had decreased range of motion with spasm and decreased motor in plantar flexion and dorsiflexion. Sensation was decreased in multiple dermatomes. Cauda equina syndrome and failed back surgery syndrome were the diagnoses. She was to follow-up with [REDACTED]. Pain medications included Norco, gabapentin, and Cymbalta and she was to continue her home exercises. On 06/23/14, she still had constant low back pain that was severe with spasms. She was still using a walker. A CT scan and spinal cord stimulator trial were ordered. On 07/08/14, she still had constant low back pain with bilateral leg weakness and was using a walker. Her right leg was giving out. She was to continue following up with the surgeon [REDACTED]. A CT scan of the lumbar spine was ordered and she was continued on gabapentin, Ambien, and Norco. A home therapy kit was recommended. In late 2013, a Psychological Evaluation was recommended but there is no evidence that it was completed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg QTY: 120.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain, page 110, Medications for Chronic Pain, page 94 Page(s): 110, 94.

Decision rationale: The history and documentation do not objectively support the request for the opioid; Norco 10/325 mg and one half the requested quantity (or #60) may be recommended for weaning purposes. The MTUS outlines several components of initiating and continuing opioid treatment and states "a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." In these records, there is no documentation of trials and subsequent failure of or intolerance to first-line drugs such as acetaminophen or non-steroidal anti-inflammatory drugs. She was given Cymbalta, likely for

depression, as a psychological evaluation was also recommended in late 2013, but there is no evidence of trials of other antidepressants for chronic pain. MTUS further explains, "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." Additionally, MTUS and ODG state "relief of pain with the use of medications is generally temporary and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication to be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medication should show effects within 1 to 3 days. A record of pain and function with the medication should be recorded. There is also no indication that periodic monitoring of the claimant's pattern of use and a response to this medication, including assessment of pain relief and functional benefit, has been or will be done. There is no evidence that she has been involved in an ongoing rehab program to help maintain any benefits she received from treatment measures. Additionally, the 4A's "analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors" should be followed and documented per the guidelines. The claimant's pattern of use of Norco is unclear other than she takes it (UDS was positive). There is no evidence that a signed pain agreement is on file at the provider's office and no evidence that a pain diary has been recommended and is being kept by the claimant and reviewed by the prescriber. As such, the medical necessity of the ongoing use of Norco has not been clearly demonstrated and #60 of Norco 10/325 is not medically necessary.

Urine Drug Screen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing, page 77 Page(s): 77.

Decision rationale: The history and documentation do not objectively support the request for a urine drug screen. The MTUS state "drug tests may be recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs." In this case, there is no evidence that illegal drug use or noncompliance with recommended medication use may be suspected. The claimant reportedly has been compliant with her medication use and a past drug screen was consistent. It is not clear why a repeat drug screen has been requested. The specific indication for a repeat drug screen has not been described and none can be ascertained from the records. The medical necessity of this request is not medically necessary.

Follow-up with spine surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7, Consultations.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Office Visits.

Decision rationale: The history and documentation do not objectively support the request for a follow up with a Spine Surgeon. The MTUS state "referral for surgical consultation is indicated for patients who have: Severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms. Clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. Failure of conservative treatment to resolve disabling radicular symptoms If surgery is a consideration, counseling regarding likely outcomes, risks and benefits, and, especially, expectations is very important. Patients with acute low back pain alone, without findings of serious conditions or significant nerve root compromise, rarely benefit from either surgical consultation or surgery. If there is no clear indication for surgery, referring the patient to a physical medicine practitioner may help resolve the symptoms. Before referral for surgery, clinicians should consider referral for psychological screening to improve surgical outcomes, possibly including standard tests such as the second edition of the Minnesota Multiphasic Personality Inventory (MMPI 2). In addition, clinicians may look for Waddell signs during the physical exam."The ODG state regarding office visits, "recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible."In this case, the claimant has very chronic pain and has seen the Spine Surgeon, [REDACTED] on multiple occasions. A CT scan and spinal cord stimulator trial were recommended but were denied. There is an indication that a psychological evaluation was recommended but no evidence that it was completed. There is no evidence that surgery is being planned, is under consideration, or is likely to be recommended. Therefore, the request is not medically necessary.

Physical Therapy for the low back QTY: 12.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Treatment, page 130 Page(s): 130.

Decision rationale: The history and documentation do not objectively support the request for an additional 12 visits of PT at this time. However, two visits may be recommended for re-evaluation of her current HEP and retraining as needed. Her exercise program has not been described and may need to be updated. The claimant has likely attended PT following her surgery and, on multiple occasions, she has been advised to continue her home exercise program. The CA MTUS Chronic Pain Guidelines, p. 130 state physical medicine treatment may be indicated for some chronic conditions and "patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." There is no evidence that an extensive course of PT is likely to resolve her chronic complaints and no evidence has been provided to support her inability to continue her rehab with an independent home exercise program. The anticipated benefit to the claimant of an extended course of PT has not been described and none can be ascertained from the records. The medical necessity of this request for 12 visits of physical therapy has not been clearly demonstrated. However, again, 2 visits appear to be appropriate for HEP reinstruction as needed to make sure she is doing her exercises properly. Therefore, the request is not medically necessary.

Home Health Assistant (4 days a week, 8 hours a day for 6 months): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Home Health Services.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services, page 84 Page(s): 84.

Decision rationale: The history and documentation do not objectively support the request for a home health assistant 4 days a week, 8 hours a day for 6 months. The MTUS state home health services may be "recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed." In this case, the specific indication for home health services has not been described and none can be ascertained from the records. The claimant is not described as being homebound and though she uses a walker, there is no description that she needs skilled care. It is not clear why this type of assistant is needed specifically for 6 months. Therefore, the request is not medically necessary.