

Case Number:	CM15-0100545		
Date Assigned:	06/03/2015	Date of Injury:	10/31/2012
Decision Date:	07/01/2015	UR Denial Date:	05/05/2015
Priority:	Standard	Application Received:	05/26/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 53-year-old male with an industrial injury dated 10/31/2012. The mechanism of injury is documented as a fall landing on the left side of his body. He stated his symptoms included headaches, vomiting and knee pain. Prior treatment included TENS unit, ice, massage, medication, physical therapy and a fusion at cervical 5-6. His diagnoses included cervical spinal stenosis, pain (psychogenic), long-term use of medications and sciatica. Co morbid diagnosis was diabetes. He presents on 04/16/2015 for follow up of neck, low back and left knee pain. The treating physician also documents the injured worker needed psychiatric care for his ongoing depression. His medications included Naproxen (Anaprox), Norco, Aspirin, Lisinopril and Metformin. In the progress note dated 12/01/2014, the injured worker was complaining of sadness, weight loss, lack of interest in activities and lack of energy. The provider documented the injured worker provided a urine sample at the 04/16/2015 visit which was negative for all substances except THC. The provider notes the injured worker has a medical marijuana card and the injured worker had not been taking Norco for the past 3-4 days due to running out of medication. Documentation states DEA CURES report is consistent with the injured worker only receiving medication from the provider's office. Prior progress note dated 12/15/2014 documents the injured worker was positive for methamphetamine and THC at the previous visit. The request is for 12 sessions of psychiatric follow up and medication management and Norco 10/325 mg # 90.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 sessions of psychiatric follow up and medication management: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398-405.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, follow up medical visits.

Decision rationale: The ACOEM and California MTUS do not specifically address the requested services. The ODG states follow up reevaluation are based on medical necessity as evidence by ongoing symptoms/complaints and gauged by response to treatment. The request is for follow up visits times 12. Without knowing the patients response to therapy, this amount is not medically necessary, as ongoing need for the future cannot be determined.

Norco 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Short Acting Opioids, Criteria for Use of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-84.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (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 nonadherent) 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 for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain dairy that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of

misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids: (a) If the patient has returned to work; (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox- AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant decrease in objective pain measures such as VAS scores for significant periods of time. There are no objective measures of improvement of function. Therefore, all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.