

Case Number:	CM15-0147956		
Date Assigned:	08/11/2015	Date of Injury:	12/01/1999
Decision Date:	09/24/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	07/30/2015

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: New York

Certification(s)/Specialty: Anesthesiology

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 66 year old female, who sustained an industrial injury on December 1, 1999. The mechanism of injury was not provided in the medical records. The injured worker has been treated for low back complaints. The diagnoses have included low back pain, failed back surgery syndrome, bilateral lower extremity radiculitis, chronic pain syndrome, incisional hernia, anxiety and depression secondary to chronic pain. Documented treatment and evaluation to date has included medications, radiological studies, computed tomography scan, home care, lumbosacral support, home exercise program and two lumbar spine surgeries. The injured worker was not working. Current documentation dated June 12, 2015 notes that the injured worker reported constant severe low back pain with radiation to the bilateral lower extremities. The pain was characterized as cramping and burning. Associated symptoms included weakness, numbness and tingling. The injured workers condition was noted to be worsening and the pain was rated a 7 out of 10 on the visual analogue scale with medications. The pain medication was effective for 1- 2 hours. Examination of the lumbar spine revealed tenderness to palpation over the paravertebral muscles. There were spasms and guarding noted over the lumbar spine. Range of motion was decreased in all planes. A straight leg raise test was positive. The documentation notes that the injured worker was able to perform activities of daily living and participate in a home exercise program with medications. The documentation noted was handwritten and difficult to decipher. The treating physician's plan of care included requests for MS Contin 60 mg # 60, Robaxin 750 mg # 120 continued home care-six hours-week, seven days-week for one year and a pain management consultation for consideration of a lumbar spine morphine pump.

IMR ISSUES, DECISIONS AND RATIONALES

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

MS Contin 60mg #60: 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 the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to ODG and MTUS, MS Contin (Morphine Sulfate Controlled-Release) is a controlled-release preparation that should be reserved for patients with chronic pain, who are in need of continuous treatment. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. For opioids, such as MS Contin, to be supported for longer than 6 months, there must be documentation of decreased pain levels and functional improvement. A satisfactory response to treatment may be indicated by decreased pain, increased level of function, and/or improved quality of life. In this case there was no evidence of functional benefit or response to ongoing analgesic therapy, to support continuation of this medication. Medical necessity of the requested medication has not been established. Of note, discontinuation of MS Contin should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

Robaxin 750mg #120: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63.

Decision rationale: Robaxin (Methocarbamol) is an antispasmodic muscle relaxant. The mechanism of action is unknown, but appears to be related to central nervous system depressant effects with related sedative properties. According to CA MTUS Guidelines, muscle relaxants are not recommended for the long-term treatment of chronic pain. They are not recommended to be used for longer than 2-3 weeks. There is no documentation of functional improvement from any previous use of this medication. According to the guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

Continue home care; six hours/week, seven days/week for one year: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

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

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines recommend home health services for patients who are home-bound, 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, 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, there is lack of documentation that the injured worker was home-bound and no indication as to what medical treatment was needed. The request for continued home care-six hours-week, seven days-week for one year is not medically necessary.

Pain management consultation for consideration of lumbar spine morphine pump: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92.

Decision rationale: According to the CA MTUS/ACOEM, a consultation is indicated to aid in the diagnosis, prognosis, and therapeutic management, determination of medical stability, and permanent residual loss and/or, the injured worker's fitness to return to work. In this case, there is no specific rationale identifying the medical necessity of the requested Pain Management consultation. According to the guidelines, evaluation and treatment of an injured worker can be handled safely and effectively by a primary care provider in the absence of red flags. There is no documentation that diagnostic and therapeutic management has been exhausted within the present treating provider's scope of practice. Medical necessity for the requested pain management consult and follow-up in six weeks has not been established. The requested services are not medically necessary.