

Case Number:	CM15-0165994		
Date Assigned:	09/03/2015	Date of Injury:	11/01/1999
Decision Date:	10/06/2015	UR Denial Date:	07/24/2015
Priority:	Standard	Application Received:	08/24/2015

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 55-year-old female who sustained an injury on 11-1-99. The examination on 12-19-14 reports follow up for low back pain with bilateral upper and lower extremity complaints. An MRI was authorized of the lumbar spine but did not have it done. She complains of constant sharp stabbing low back pain rated at 6 out of 10. Diagnoses are DDD cervical spine with radiculopathy; DDD lumbar spine with radiculopathy; cervical stenosis; lumbar stenosis; multilevel disc herniation of cervical and lumbar spine. Treatment plan included physical therapy, chiropractic treatment, acupuncture, multiple pain management techniques, injections or surgery. Medications included Norco 1-325 mg; Temazepam 50 mg. 5-15-15 follow up exam for low back pain with bilateral upper and lower extremity complaints. She states her symptoms remain persistent and unchanged. She uses a three point cane for ambulation; continues with home exercise program and stretches daily. She is currently not working. Treatment history includes 12 sessions of physical therapy with moderate relief; 24 sessions of chiropractic physiotherapy with moderate relief; 24 sessions acupuncture with moderate relief. Medication includes Norco 10325 mg, relief for 3-4 hours; Temazepam 50 mg 2 tablets at night, minimal relief. Her pain has decreased 50-60% with these medications. Her current complaints in the low back are intermittent sharp pain across the belt line rated at 8 out of 10 and are aggravated with prolonged walking and sitting. She complains of constant stabbing pain down the bilateral lower extremity to toes, left leg worse than right leg. Objective findings in the spine are limited range of motion of the lumbar spine in all planes; decreased sensation of the bilateral C5 and C6 dermatomes; decreased sensation of the bilateral L4, L5 and S1 dermatomes. It was noted that

her condition has worsened with increased neck and arm complaints. A recommendation for an MRI cervical spine and she would like to proceed with an injection for her neck. Medications prescribed were Norco 10-325 mg for seer pain; continue Temazepam 50 mg. The PR2 dated 6-3-15 requests MRI of the cervical spine; med panel to evaluate complications of medication use and maximize medication safety and that medication refills should be done in pain management. Current requested treatments MRI of the cervical spine; pain management consultation; med panel.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178-179.

Decision rationale: The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: Criteria for ordering imaging studies are: Emergence of a red flag. Physiologic evidence of tissue insult or neurologic dysfunction. Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure. The provided progress notes fails to show any documentation of indications for imaging studies of the neck as outlined above per the ACOEM. There was no emergence of red flag. The neck pain was characterized as unchanged. The physical exam noted no evidence of new tissue insult or neurologic dysfunction. There is no planned invasive procedure. Therefore, criteria have not been met for a MRI of the cervical spine and the request is not certified.

Pain Management consultation: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 3 Initial Approaches to Treatment.

Decision rationale: Per the ACOEM :The health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for 1. Consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. The patient upon review of the provided medical records has ongoing back pain despite conservative therapy. The referral for pain management would thus be medically necessary and approved.

Med Panel: Overturned

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

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: 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 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 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 diary 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 non-opioid 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. The California MTUS does recommend urine drug screens as part of the criteria for ongoing use of opioids. The patient was on opioids at the time of request and therefore the request is medically warranted.