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| Case Number: | CM15-0168694 | | |
| Date Assigned: | 09/09/2015 | Date of Injury: | 02/24/2003 |
| Decision Date: | 10/08/2015 | UR Denial Date: | 08/11/2015 |
| Priority: | Standard | Application Received: | 08/27/2015 |

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 58 year old female who sustained an industrial injury on 2-24-03. A review of the medical records indicates that the injured worker is undergoing treatment for cervical musculoligamentous sprain and strain with bilateral upper extremity radiculitis and 2-3 millimeter disc bulges at the C5-6 and C6-7 levels and a 3-4 millimeter disc bulge at C7-T1 with mild central canal stenosis at C5-T1; mild to moderate facet osteoarthritis and bilateral wrist and forearm tendinitis, de Quervain's tenosynovitis and left carpal tunnel syndrome with history of right carpal tunnel release on 7-10-08. Medical records (2-19-15 to 7-23-15) indicate ongoing pain in her neck that radiates to bilateral wrists. The pain has noted to improve from "6-7 out of 10" to "4-5 out of 10 with medications" (7-23-15). The records indicated that she has had improvement in her ability to participate in activities of daily living, stating that she is "better able to do housework, cooking and dishes, laundry, bathing, and dressing" (7-23-15). She is also noted to have improved ability to stand, sit, and walk for longer periods of time, as well as lift more weight (7-23-15). The physical exam indicates decreased range of motion in wrists, bilaterally. This has not changed within the review period. Her treatment has included oral medications, namely Neurontin 300mg twice per day and Norco 5-325 two tablets per day, acupuncture, home exercises, bracing, and a cervical epidural injection. She has not been working throughout the review period and has restrictions of no heavy lifting, forceful pushing or pulling, or repetitive or forceful gripping or grasping (5-6-15). The treating physician requested authorization for urine toxicology on the 7-23-15 visit. A request for authorization, dated 7-23-15, includes Norco 5-325 every 12 hours as needed, #60, and 6 sessions of

chiropractic therapy. The original utilization review (8-11-15) denied the use of Norco, indicating that it "is no longer warranted". This was noted by "no findings present to support significant functional benefit or improvement from chronic use". The request for chiropractic services was also denied, as the injured worker had previously completed chiropractic treatment and it "did not reveal changes in subjective complaints or show evidence of functional improvement".

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Norco 5/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain.

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 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. 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.

6 sessions of chiropractic treatment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: The California chronic pain medical guidelines section on manual manipulation states: Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care not medically necessary. Recurrences/flare-ups need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines a. Time to produce effect: 4 to 6 treatments. Manual manipulation is recommended form of treatment for chronic pain. However the requested amount of therapy sessions is in excess of the recommendations per the California MTUS. The California MTUS states there should be not more than 6 visits over 2 weeks and documented evidence of functional improvement before continuation of therapy. The request is for 8 sessions. Previous sessions however did not produce documented improvement in pain and function and therefore the request is not medically necessary.