

Case Number:	CM15-0047973		
Date Assigned:	03/20/2015	Date of Injury:	06/28/2010
Decision Date:	04/24/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/13/2015

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, Tennessee
Certification(s)/Specialty: Emergency Medicine

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 42 year old male who sustained an industrial injury on 6/28/2010. The initial reported injuries were noted to include pain in the left hip, left arm, the back and the sacrum. The injured worker was diagnosed as having joint pain - pelvis; left hip fracture/dislocation; non-industrial wound abscess - right foot (treated as industrial due to industrial hip injury); open reduction internal fixation of left foot fracture, and removal of distal femoral pin; non-displaced distal radius fracture; post-traumatic stress disorder (PTSD); degenerative lumbo-sacral intervertebral disc; lumbar spondylosis, and hip and back pain. Treatments to date have included consultations; diagnostic laboratories; bone scan (5/2011); magnetic resonance imaging arthrogram (5/26/11); magnetic resonance imaging - lumbar (7/7/11 & 3/8/13); electromyogram (8/26/11); physical therapy; agreed medical examination (8/24/12); bilateral lumbosacral medial branch blocks; psychotherapy, individual and group, for PTSD; and medication management. The current medical evaluation dated 2/12/2015, noted no chief complaints, and that he underwent psychiatric diagnostic evaluation and psychological testing for chronic pain, resulting in determinations for chronic pain disorder with significant insomnia and psychiatric comorbidities, and the request for additional psychology sessions and pain medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 Psychology sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Cognitive Behavioral Therapy (Chronic pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 101-102. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain, Behavioral Interventions.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines state that psychological treatment is recommended for appropriately identified patients during treatment for chronic pain. The guidelines also state that psychological intervention includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders. There should be an initial trial of 3-4 visits of psychotherapy over 2 weeks to determine if there is functional improvement. With evidence of objective functional improvement, recommended number of visits is a total of up to 6-10 visits over 5-6 weeks. In this case the patient had at least 6 visits with a pain and psychiatry specialist. There is no documentation that prior psychotherapy has provided sustained functional benefit. Therefore, this request is not medically necessary.

(1) Prescription of Hydrophone-Acetaminophen 10/325mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, on-going management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines.

Decision rationale: Hydrocodone-acetaminophen is a compounded medication containing hydrocodone and acetaminophen. MTUS Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short term use if first-line options, such as acetaminophen or NSAIDS have failed. Opioids may be a safer choice for patients with cardiac and renal disease than antidepressants or anticonvulsants. Acetaminophen is recommended for treatment of chronic pain & acute exacerbations of chronic pain. Acetaminophen overdose is a well-known cause of acute liver failure. Hepatotoxicity from therapeutic doses is unusual. Renal insufficiency occurs in 1 to 2% of patients with overdose. The recommended dose for mild to moderate pain is 650 to 1000 mg orally every 4 hours with a maximum of 4 g/day. In this case, the patient has been receiving hydrocodone-acetaminophen since at least August 2011 and has not obtained analgesia. Criteria for long-term opioid use have not been met. Therefore, this request is not medically necessary.