

Case Number:	CM15-0051296		
Date Assigned:	03/24/2015	Date of Injury:	05/15/2008
Decision Date:	05/01/2015	UR Denial Date:	03/13/2015
Priority:	Standard	Application Received:	03/18/2015

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: Internal 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 58 year old female injured worker suffered an industrial injury on 05/15/2008. The diagnoses were complex regional pain syndrome, major depression and lumbar, thoracic and cervical degenerative disc disease, right/left knee sprain and right/left shoulder sprain. The diagnostics included psychological testing 10/24/2014. The injured worker had been treated with spinal cord stimulator, medications, physical therapy. On 2/10/2015 the treating provider reported she was in a wheelchair with severe tenderness in the lumbar area. Both lower extremities had atrophy with reduced strength. The pain was rated as 8/10. The treatment plan included Pain Psychological consultation, Inpatient rehabilitation services, and Butrans patch.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain Psychological consultation: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 127.

Decision rationale: ACOEM states that 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/Psychological consultations. The claimant has chronic pain, depression, and anxiety. Per the documentation she had psychological testing 10/14 with recommendations for treatment. There is no specific indication for the requested consultation. Medical necessity for the requested service is not established. The requested service is not medically necessary.

Inpatient rehabilitation services: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare coverage criteria for Inpatient Rehabilitation Programs.

Decision rationale: Per Medicare guidelines, inpatient rehabilitation services are indicated in the following situations: The patient no longer has acute medical needs that require acute inpatient hospital care. The complexity of the patient's nursing, medical management and rehabilitation needs require an integrated multidisciplinary approach that includes ALL of the following: The intensity, frequency and duration of therapeutic activities make it impractical to obtain the services in a less intensive setting Frequent assessment and evaluation by the multifunctional rehab team, including the physiatrist or rehabilitation trained physician specialist, are required because of complex needs and potential changes in medical or physical status, and access to rehabilitation nursing care (RN) is needed 24 hours a day, 7 days a week. The documentation indicates the claimant has chronic low back pain with radiculopathy. She has undergone multiple treatment modalities including participation in an outpatient functional rehabilitation program. The claimant meets none of the criteria for an inpatient rehabilitation program. Medical necessity for the requested service is not established. The requested service is not medically necessary.

Butrans patch 5mcg/hr quantity 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines When to Discontinue Opioids; Weaning of Medications.

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- Opioids.

Decision rationale: According to CA MTUS and ODG, Buprenorphine is a semisynthetic opioid derivative of the baine. It is a mixed agonist antagonist opioid receptor modulator that is used to treat opioid addiction in higher dosages, to control moderate acute pain in non-opioid-tolerant individuals in lower dosages and to control moderate chronic pain in even smaller doses. Opioid drugs are available in various dosage forms and strengths. They are considered the most

powerful class of analgesics that may be used to manage both acute and chronic pain. These medications are generally classified according to potency and duration of dosage duration. 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. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. Medical necessity of the requested item has not been established. The requested item is not medically necessary.