

Case Number:	CM14-0131758		
Date Assigned:	08/20/2014	Date of Injury:	08/24/2005
Decision Date:	09/24/2014	UR Denial Date:	08/15/2014
Priority:	Standard	Application Received:	08/18/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and Pain Medicine, has a subspecialty in Interventional Spine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 46-year-old female with a date of injury of 08/24/2005. The listed diagnoses per [REDACTED] are: 1. Chronic myofascial pain syndrome, cervical and thoracic spine. 2. Mild to moderate bilateral carpal tunnel syndrome and mild ulnar nerve entrapment, bilateral elbows. 3. Status post surgical release of right carpal tunnel syndrome. 4. Status post surgery for left thoracic outlet syndrome, 2000, nonindustrial. 5. Depression and insomnia. According to progress report 07/21/2014, the patient presents with constant neck, upper and lower back pain that is noted as frequent with numbness into both her hands. Patient notes with her current medications she is able to perform activities of daily living and work on a full-time basis. Without medication, her pain varies from 7-9/10. Examination revealed slight to moderate restricted range of motion in the cervical spine. Range of motion of the lumbar spine was moderately restricted in all planes as well. There were multiple myofascial trigger points and taut bands noted throughout the cervical paraspinal, trapezius, levator scapula, infraspinatus, and thoracic paraspinal musculature. Spurling's and neck compression tests were both positive. Patient was not able to perform heel-toe gait. The provider is requesting a refill of hydrocodone/APAP 10/325 mg #180 and aquatic therapy exercises 2 times a week for 6 weeks. Utilization review denied the request on 08/15/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 10/325mg #180: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid use Page(s): 88-89.

Decision rationale: The provider is requesting a refill of hydrocodone/APAP 10/325 mg #180. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Review of the medical file indicates the patient has been taking this medication since 08/06/2013. Utilization review modified the medical necessity from the requested #180 to #90. In this case, the provider indicates the patient receives over 50% pain relief with this medication and has been able to return to full-time work. He notes patient is able to perform activities of daily living with more than 50% with taking hydrocodone. He indicates the patient is administered routine drug screens, and there are no side effects to this medication. Given the provider's documentation of the efficacy of this medication, recommendation is medically necessary.

Aquatic therapy #12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy:Physical Medicine Page(s): 22, 98, 99.

Decision rationale: The provider is requesting aquatic therapy 3 times a week for 4 weeks. MTUS recommends aquatic therapy as an option for land-based physical therapy in patients that could benefit from decreased weight bearing, such as extreme obesity. For number of treatments, MTUS Guidelines page 98 and 99 recommends for myalgia-, myositis-, and neuritis-type symptoms, 9 to 10 sessions over 8 weeks. There are no weights bearing restrictions for this patient. The provider does not discuss why the patient would not be able to participate in land-based therapy. Furthermore, the provider's request for 12 sessions exceeds what is recommended by MTUS. Recommendation is not medically necessary.