MAXIMUS Federal Services

Case Number:	CM14-0211988		
Date Assigned:	01/02/2015	Date of Injury:	06/05/2007
Decision Date:	02/20/2015	UR Denial Date:	11/25/2014
Priority:	Standard	Application Received:	12/17/2014

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. 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: California
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:

This 59-year-old dental office manager reported multiple injuries after a fall in which she hit her head on a wall and fell to the floor on 6/5/07. Treatment has included low back and bilateral shoulder surgery, an injection of the left wrist for carpal tunnel syndrome, bilateral breast reductions for neck pain, medications, physical therapy, multiple Botox injections, and psychotherapy including 20 visits cognitive behavioral therapy for pain management counseling. She has been taking multiple medications for years, including Norco, Valium, Soma, Wellbutrin, Mobic, Lidoderm, Meclizine and Lorazepam. Soma has been non-certified in UR multiple times but continues to be prescribed. Likewise, Norco has been modified to a smaller number than requested to allow for weaning or has been completely non-certified several times in UR but continues to be prescribed. The patient has not worked since 12/07. An 8/12/14 progress note states that the patient had recently fallen and hit her head on a rock while on vacation in Hawaii. She had been diagnosed as having a new, non-industrial post-concussion syndrome. Most of the notes from her current primary treater state that she will not be returning to work. A psychiatric AME report of 6/25/14 notes that the patient has probably had over 100 sessions of psychotherapy. The AME deems her psychiatrically permanent and stationary as of June 2013. The note states that the patient's depressive and anxiety symptoms are more or less the same as they were in 2010, and that there has been no real change in her global assessment of function. The patient's primary treater sees her regularly, and frequently administers Botox injections or trigger point injections to her neck and shoulder muscles. On 11/17/14 the primary treater noted that the patient continues to have chronic neck, low back, left shoulder, and bilateral wrist pain.

Physical findings include tenderness of the paracervical muscles and trapezius, and limited neck range of motion. Spurling's test is negative for radicular symptoms. Diagnoses include torticollis, cervical disc degeneration, brachial neuritis or radiculitis, rotator cuff sprains/strains, post-concussion syndrome (non industrial), depression and post lumbar laminectomy syndrome. Medications include Norco 10/325 4 times per day as needed, as well as Valium, Soma, Wellbutrin, Mobic, Lidoderm patch, Meclizine and Lorazepam. Plan includes a request for an adjustable bed since the patient is unable to sit up on her own due to her recent head injury, for which she is to continue follow up with a neurologist on a non-industrial basis. The treater recommends a new course of cognitive behavioral therapy to help the patient cope with her injury. All current medications are to be continued. Requests for 6 pain management counseling sessions and for Norco 10/325 were non-certified in UR on 11/25/14. MTUS Chronic Pain Guidelines were cited for both the Norco and therapy non-certifications. ODG Pain chapter, Psychological Treatment was also cited for the therapy non-certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

Six (6) pain management counseling sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention, Chapter 3 Initial Approaches to Treatment, Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 9; 48; 101-102. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter, Psychological Treatment.

Decision rationale: Per the MTUS Chronic Pain citations, all therapies should be focused on the goal of functional improvement rather than just pain elimination, and assessment of treatment efficacy is accomplished by reporting functional improvement. It is important to have specific measures that can be used repeatedly to demonstrate improvement or maintenance of function over the course of treatment. These should include the categories of work functions or ADLs, self-report of disability (walking, lifting, keyboard or driving tolerance) and pain scales. Objective measurements of functional improvement are preferred, such as measuring the patient's ability to lift 10 pounds from floor to waist repetitively, but they are not required. The provider should document assessment of the patient's compliance with a home program and motivation.The MTUS Chronic Pain citation states that psychological treatment is recommended for appropriate patients, and that cognitive behavioral therapy and self-regulatory treatments are particularly effective. However, when pain is sustained in spite of continued therapy, a multidisciplinary pain program may be required. According to the ODG citation, therapy may include up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made. (The provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate.)The clinical documentation in this case does not support the provision of an additional 6 pain counseling sessions to this patient. She has already had 20 cognitive therapy visits for pain counseling, and apparently more than 100 psychotherapy visits in general. She does not appear to have made any

psychological or functional progress as a result of these visits. The 6/25/14 psychiatric AME report documents her as psychologically unchanged since 2010. The primary treater has documented no functional goals for this patient. Several of the provider's recent notes document that the patient is not psychologically ready for a functional recovery program. The patient remains off work and unable to return to work, which implies a profound and unchanging level of disability. According to the evidence-based citations above and to the clinical documentation provided for my review, 6 pain management counseling sessions are not medically necessary. They are not medically necessary because the patient has made no functional recovery with the multiple pain management sessions and other psychotherapy sessions already provided to her, and because it does not appear likely that continuing the same course will yield different results.According to the evidence-based citations above and to the clinical documentation provided for my review, 6 pain management counseling sessions are not medically necessary. They are not medically necessary because the patient has made no functional recovery with the multiple pain management sessions and other psychotherapy sessions already provided to her, and because it does not appear likely that continuing the same course will yield different results.

Norco 10/325 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain; Criteria for Use of Opioids, Steps to Take Before a Therapeutic Tr.

Decision rationale: Norco 10/325 is brand-name hydrocodone 10 mg with acetaminophen 325 mg. Hydrocodone is an opioid analgesic. Per the MTUS recommendations cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it.Opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine if the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Opioids should be discontinued if there is no improvement in function. There is no good evidence that opioids are effective for radicular pain. If long-term use of opioids occurs, there is a need for ongoing pain and function assessments, as well as assessments for side effects, of concurrent other treatments, and of concurrent psychological issues.The clinical findings in this case do not demonstrate that any of the above criteria have been met. This patient has been prescribed Norco for years. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. The patient's diagnoses of brachial neuritis or radiculitis and of carpal tunnel syndrome would suggest that the patient's pain is at least in part neuropathic, and may not respond well to opioids. No assessment is documented of whether or not opioid use was likely to be helpful in this patient, or of her potential for abuse. No specific functional goals were set or followed. Most importantly, Norco was not discontinued when it became clear that it has not produced any functional improvement. The patient's status has remained at totally disabled, which implies that she has profound disabilities and inability to do even the lightest sedentary work. Based on the

evidence-based guidelines cited above, and the clinical documentation provided for my review, Norco 10/325 is not medically necessary. It is not medically necessary because of the lack of appropriate documentation of the patient's status prior to beginning it, because of the failure to set and monitor functional goals, and because of the failure to discontinue it when it became clear that it has not produced any functional recovery.