

Case Number:	CM15-0179710		
Date Assigned:	09/21/2015	Date of Injury:	06/28/2000
Decision Date:	10/23/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	09/12/2015

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 45 year old female, who sustained an industrial injury on 6-28-2000. The injured worker was diagnosed as having cervical spine disc bulge, carpal tunnel syndrome bilateral wrists, lumbar spine disc bulge, and right knee meniscal tear. Treatment to date has included diagnostics, Orthovisc injections, and medications. Currently (8-04-2015), the injured worker complains of "severe" pain and spasm to her neck, as well as pain and spasm to her low back. She also continued to have radiating symptoms, including pain and numbness, running down her bilateral upper extremities, and "severe" pain and numbness to her bilateral hands. She had difficulty with use of her hands, with significant sensitivity. She had difficulty with prolonged sitting and standing secondary to pain. She reported that a slip and fall one day prior increased her symptoms. Pain was not rated. Exam of the cervical spine noted spasm about the bilateral trapezial areas, point tenderness upon palpation of the paraspinal area, painful and decreased range of motion, and positive distraction and compression tests. Exam of the wrists noted well healed surgical scars, and positive bilateral Tinel's and Phalen's signs. Exam of the lumbar spine noted spasm about the lower lumbar region, point tenderness to palpation of the paraspinal area, and decreased range of motion. Exam of the right knee noted mild effusion, point tenderness to palpation about the medial and lateral joint lines, crepitus and pain with range of motion, flexion to 110 degrees, and positive Apley's and McMurray's tests. Motor exam for the upper extremities noted 5 of 5 strength and sensation was noted to the right deltoid and all digits of the hands. Lower extremity motor strength was 5 of 5 and sensation was "normal". The use of Norco was noted since at least 4-09-2015. Her work status was permanent and

stationary, noting she was "unable to work". The treatment plan included referrals to a psychologist (prior to lumbar spine surgery-unspecified) and pain management physician (no longer comfortable with her current pain management specialist) and Norco 10-325mg #60. On 8-20-2015, Utilization Review non-certified the referrals for psychology and pain management and modified the request for Norco 10-325mg to #45.

IMR ISSUES, DECISIONS AND RATIONALES

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

Referral to a psychologist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7 page 127.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment.

Decision rationale: Per the ACOEM: The health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for; 1. Consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. The patient has no primary psychiatric diagnoses or complaints due to industrial incident. There is no mention of tried and failed therapies. Therefore the request is not medically necessary.

Referral to a pain management physician: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7 page 127.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment.

Decision rationale: Per the ACOEM: The health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for; 1. Consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. The patient has ongoing complaints of significant back and knee pain that have failed treatment by the primary treating physician. Therefore criteria for a pain management consult have been met and the request is medically necessary.

Remaining Norco 10/325 mg #15: 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 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 nonopioid 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 improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function or activity specifically due to the medication. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.