

Case Number:	CM15-0062344		
Date Assigned:	04/23/2015	Date of Injury:	10/02/2012
Decision Date:	06/11/2015	UR Denial Date:	03/12/2015
Priority:	Standard	Application Received:	04/01/2015

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: California, Texas

Certification(s)/Specialty: Psychiatry, Geriatric Psychiatry, Addiction Psychiatry

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 55 year old male whose date of injury is 10/02/2012. Prior treatments include orthotics, intra-corticosteroid injection of the right knee, physical therapy and medications. He currently complains of debilitating pain in the right foot and ankle rated 8/10. Diagnoses are right knee medial meniscus tear, right ankle avascular necrosis, left knee internal depression NOS, medication induced gastritis, and left hip sprain/strain. Medications include Prilosec, Anaprox, Norco and Ultracet; as well as Cymbalta and mirtazapine. He has been on Norco since at least 06/2013. In an office visit of 03/26/15, the patient indicated that he obtains 40-50% pain relief with Norco lasting 4-5 hours. He complained of increased pain in the left hip, knee, and low back, and cramping in the calves. In 08/2014, he had been certified for 6 CBT sessions. In a psychological evaluation of 02/27/15, he scored in the moderate range of anxiety and depression on the Beck Inventories and the assessment was that he had showed only mild improvement. This was felt to be due his functional limitations caused by pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Ultracet #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), 7th edition, 2011, Tramadol.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Specific Opioids: Tramadol: A recent Cochrane review found that this drug decreased pain intensity, produced symptom relief and improved function for a time period of up to three months but the benefits were small (a 12% decrease in pain intensity from baseline). Adverse events often caused study participants to discontinue this medication, and could limit usefulness. There are no long-term studies to allow for recommendations for longer than three months. (Cepeda, 2006) Similar findings were found in an evaluation of a formulation that combines immediate-release vs. extended release Tramadol. Adverse effects included nausea, constipation, dizziness/vertigo and somnolence (Burch 2007). Page(s): 84 of 127.

Decision rationale: The patient has been on chronic opioid therapy with Norco since at least 06/2013. No rationale was provided for prescribing Ultracet (tramadol) what would be double opioid treatment. This request is therefore noncertified, not medically necessary.

Norco 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Short-acting Opioids, On-going Management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids 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). Page(s): 78 of 127.

Decision rationale: The patient consistently reports pain of 8/10. He most recently reported increasing pain and cramping in the calves. He has been prescribed the opioid Norco since at least 06/2013, and despite what can now be considered chronic opioid therapy he has not demonstrated objective functional improvement therefore request is not medically necessary.

Cognitive Behavioral Psychotherapy x 10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Treatment, Behavioral Interventions. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cognitive Behavioral Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions Recommended. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. See also Multi-disciplinary pain programs.ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain: Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See Fear-avoidance beliefs questionnaire (FABQ). Initial therapy for these at risk patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from physical medicine alone: Initial trial of 3-4 psychotherapy visits over 2 weeks, With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions). Page(s): 24 of 127.

Decision rationale: The patient was certified for 10 CBT sessions in 08/2014. It is unclear how many of those visits he actually received. On 02/27/15, psychological testing showed him to be in the moderate range of anxiety and depression, with only mild improvement to date. As there does not appear to be adequate objective functional improvement this request is therefore noncertified, not medically necessary.