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| Case Number: | CM13-0022496 | | |
| Date Assigned: | 01/29/2014 | Date of Injury: | 08/07/2003 |
| Decision Date: | 08/04/2014 | UR Denial Date: | 09/03/2013 |
| Priority: | Standard | Application Received: | 09/10/2013 |

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 is licensed to practice in Texas and Ohio. 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 injured worker is a 67-year-old male who reported an injury on August 07, 2003 due to an unknown mechanism of injury. The injured worker's treatment history included multiple medications, acupuncture, assisted ambulation, and surgical intervention. The injured worker's diagnoses included lumbago. The injured worker was evaluated on August 12, 2013. It was documented that the injured worker was attempting to reduce medication usage. It is noted that the injured worker had a recent loss of balance that caused significant injury to his right arm that required surgery. A request was made for acupuncture to assist with pain medication reduction, a front wheel walker to assist with ambulation, a functional restoration evaluation and program to assist with medication reduction, a refill of medications, an occupational and physical therapy to address gait and balances.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture for the Low Back (4 sessions): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The requested 4 sessions of acupuncture for the low back is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend the use of acupuncture to assist with pain medication reduction. However, it is noted that the injured worker will undergo surgical intervention for the arm. In anticipation of this surgical intervention, reduction in pain medication would not be appropriate for this injured worker until the acute phase of pain following surgical intervention had subsided. As such, the requested 4 sessions of acupuncture for the low back is not medically necessary or appropriate.

A Front Wheel Walker: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: The requested front wheel walker is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this request. The Official Disability Guidelines recommend a front wheel walker for injured workers who have ambulation deficits that require assistance. The clinical documentation submitted for review does indicate that the injured worker recently sustained a fall causing a right arm injury. Therefore, it is unclear how a front wheel walker would be functional for this injured worker as they would not be able to lift or steer the device without the use of the right arm. As such, the requested front wheel walker is not medically necessary or appropriate.

Functional Restoration Program: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 30.

Decision rationale: The requested functional restoration program is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends a functional restoration program for injured workers who have chronic pain with physical and emotional deficits that delay recovery and would benefit from coping strategies provided by a multidisciplinary program. The clinical documentation submitted for review does indicate that the patient has chronic low back pain. However, as the patient recently sustained an injury to the arm and is scheduled to undergo surgery, a functional restoration program at this juncture would not be indicated. As such, the requested functional restoration program is not medically necessary or appropriate.

Interdisciplinary Evaluation for a Functional Restoration Program: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 30.

Decision rationale: The requested interdisciplinary evaluation for functional restoration program is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends a functional restoration program for injured workers who have chronic pain with physical and emotional deficits that delay recovery and would benefit from coping strategies provided by a multidisciplinary program. The clinical documentation submitted for review does indicate that the patient has chronic low back pain. However, as the patient recently sustained an injury to the arm and is scheduled to undergo surgery, a functional restoration program at this juncture would not be indicated. As such, the requested interdisciplinary evaluation for functional restoration program is not medically necessary or appropriate.

Kadian 50mg (twice a day, #60): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested prescription of Kadian 50 mg twice a day #60 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends that opioids be supported by documentation of functional benefit, pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence of pain relief or functional benefit resulting from the use of this medication. Additionally, there was no documentation that the patient is being monitored for aberrant behavior. The clinical documentation does indicate that the injured worker has been on this medication since 2012. However, without functional benefit or pain relief, continued use would not be supported. As such, the requested prescription of Kadian 50 mg twice a day #60 is not medically necessary or appropriate.

Occupational Therapy for the Low Back (4 sessions): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The requested 4 sessions of occupational therapy for the low back is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend occupational and physical therapy for injured workers who have pain complaints and range of motion and weakness deficits. The clinical documentation submitted for review does indicate that the injured worker has ambulation deficits and lower extremity weakness that would benefit from therapeutic activity. However, it is noted within the documentation that the patient will undergo surgical intervention for the arm. Therefore, it is unclear how the patient will be able to safely and actively participate in a therapeutic program directed to the low back without the use of the right arm. As such, the requested 4 sessions of occupational therapy for the low back are not medically necessary or appropriate.

Physical Therapy for the Low Back (4 sessions): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The requested 4 sessions of physical therapy for the low back is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend occupational and physical therapy for injured workers who have pain complaints and range of motion and weakness deficits. The clinical documentation submitted for review does indicate that the injured worker has ambulation deficits and lower extremity weakness that would benefit from therapeutic activity. However, it is noted within the documentation that the patient will undergo surgical intervention for the arm. Therefore, it is unclear how the patient will be able to safely and actively participate in a therapeutic program directed to the low back without the use of the right arm. As such, the requested 4 sessions of physical therapy for the low back are not medically necessary or appropriate.

Opana IR 10mg (5 tablets daily, #150): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested prescription of Opana IR 10 mg, 5 tablets daily #150 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends that opioids be supported by documentation of functional benefit, pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence of pain relief or functional benefit resulting from the use of this medication. Additionally, there was no documentation that the patient is being monitored for aberrant behavior. The clinical documentation does indicate that the injured worker has been on this medication since 2012.

However, without functional benefit or pain relief, continued use would not be supported. As such, the requested prescription of Opana IR 10 mg, 5 tablets daily #150 is not medically necessary or appropriate.