

Case Number:	CM13-0038422		
Date Assigned:	12/18/2013	Date of Injury:	09/23/1995
Decision Date:	03/11/2014	UR Denial Date:	10/11/2013
Priority:	Standard	Application Received:	10/25/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. 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 physician 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 who reported an injury on 09/23/1995. The patient is diagnosed with intractable low back pain, morbid obesity, and failed back surgery syndrome. The patient was seen by [REDACTED] on 11/08/2013. The patient reported chronic low back pain with radiation to bilateral lower extremities. Physical examination revealed a depressed affect. Treatment recommendations included continuation of current medications, a home health care assistant, and revocation of surgery authorization.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Ambien CF 12.5 mg DOS: 12/12/12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment

Decision rationale: Official Disability Guidelines state insomnia treatment is recommended based on etiology. Empirically supported treatment includes stimulus control, progressive

muscle relaxation, and paradoxical intention. As per the documentation submitted, there was no indication of chronic insomnia or sleep disturbance. There was also no indication of a failure to respond to non-pharmacologic treatment prior to the initiation of a prescription product. As guidelines do not recommend chronic use of this medication, the current request is not medically appropriate. As such, the request is non-certified.

Retrospective request for Percocet 10/325 mg #300 DOS: 12/12/12: 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 Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient had continuously utilized this medication. Despite ongoing use, the patient continued to report persistent pain. Satisfactory response to treatment was not indicated. Therefore, the current request is not medically appropriate. As such, the request is non-certified.

Retrospective request for Lunesta 3mg DOS: 8/24/12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Library of Medicine

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment

Decision rationale: Official Disability Guidelines state insomnia treatment is recommended based on etiology. Empirically supported treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention. As per the documentation submitted, there was no indication of chronic insomnia or sleep disturbance. There was also no indication of a failure to respond to non-pharmacologic treatment prior to the initiation of a prescription product. As guidelines do not recommend chronic use of this medication, the current request is not medically appropriate. As such, the request is non-certified.

Retrospective request for Oxycontin 80mg #120 DOS: 12/12/12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient had continuously utilized this medication. Despite ongoing use, the patient continued to report persistent pain. Satisfactory response to treatment was not indicated. Therefore, the current request is not medically appropriate. As such, the request is non-certified.

Oxycontin 80mg #120 DOS: 8/24/12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient had continuously utilized this medication. Despite ongoing use, the patient continued to report persistent pain. Satisfactory response to treatment was not indicated. Therefore, the current request is not medically appropriate. As such, the request is non-certified.

Retrospect request for surgical follow-up DOS: 8/24/12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Office Visits

Decision rationale: California MTUS/ACOEM Practice Guidelines state physician follow-up can occur when a release to modified, increased, or full duty is needed, or after appreciable healing or recovery can be expected. Physician follow-up might be expected every 4 days to 7 days if the patient is off work, and 7 days to 14 days if the patient is working. As per the documentation submitted, the patient was referred to a bariatric surgeon in 2012. The medical necessity for an additional follow-up visit with a surgeon on 08/24/2012 has not been established. Therefore, the request is non-certified.

Retrospective home health care 20 hours weekly DOS: 8/24/12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter and the Medicare.gov/Publications

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

Decision rationale: California MTUS Guidelines state home health services are recommended only for otherwise recommended medical treatment for patients who are home-bound, on a part time or intermittent basis, generally up to no more than 35 hours per week. As per the documentation submitted, there was no indication that this patient was home-bound. The medical necessity has not been established. Therefore, the request is non-certified.

Retrospective request for 3 month gym membership DOS: 8/24/12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation State of Minnesota Worker's Compensation Treatment Parameter Rules, TP-59

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Gym Memberships

Decision rationale: Official Disability Guidelines state gym memberships are not recommended as a medical prescription unless a home exercise program has not been effective and there is a need for equipment. As per the documentation submitted, there was no evidence of a failure to respond to a home exercise program, nor was there evidence of the need for equipment. There is no clear rationale as to why the patient requires a structured environment to perform prescribed exercises as opposed to a home exercise program. The medical necessity has not been established. Therefore, the request is non-certified.