

Case Number:	CM13-0050363		
Date Assigned:	12/27/2013	Date of Injury:	12/30/2009
Decision Date:	03/11/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	11/13/2013

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 Orthopedic Surgery and is licensed to practice in California. 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 67-year-old male who reported an injury on 12/30/2009. The patient is diagnosed with segmental instability with spinal stenosis in the lumbar spine, grade 1 to 2 spondylolisthesis, status post L3-4 fusion in 2001, degenerative lumbosacral disc disease, and intervertebral disc displacement. The patient was recently seen by [REDACTED] on 12/12/2013. The patient reported severe lower back pain with progressive weakness in the lower extremities. Physical examination revealed diminished reflexes in bilateral knees and ankles, increased leg weakness, positive straight leg raising bilaterally, and guarding with spasm. Treatment recommendations included continuation of current medications, a second opinion for additional lumbar spine surgery, and continued use of an electric, motorized scooter.

IMR ISSUES, DECISIONS AND RATIONALES

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

motorized scooter wheelchair: 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)

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, Motorized Wheelchair Section

Decision rationale: The Official Disability Guidelines (ODG) state durable medical equipment is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. Motorized scooters are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. As per the documentation submitted, there is evidence upon physical examination of increased lower extremity weakness with muscle spasm and guarding. However, there is no evidence of an inability to function with the use of a cane or walker. There is also no evidence of an inability to self propel a manual wheelchair as opposed to a motorized scooter. Additionally, it is unknown whether there is a caregiver available to assist the patient with a manual wheelchair. Based on the clinical information received, the request is noncertified.

Butrans Patches: 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 26-27.

Decision rationale: The California MTUS Guidelines state Buprenorphine is recommended for treatment of opiate addiction. It is also recommended as an option for chronic pain, especially after detoxification in patients who have a history of opiate addiction. As per the documentation submitted, the patient has been maintained on opioid therapy since at least 2011. There is no documentation of any attempts at detoxification. The medical necessity for the ongoing use of this medication has not been established. Therefore, the request is non-certified.

Oxycodone: Upheld

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

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

Decision rationale: The 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 assessment should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. Despite ongoing use of this medication, the patient has continuously reported severe lower back pain with an inability to function. There was no change in the patient's physical examination to indicate functional improvement. Satisfactory response to treatment was not indicated. Therefore, the request is noncertified.

Cyclobenzaprine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 63-66.

Decision rationale: The California MTUS Guidelines state muscle relaxants are recommended as non sedating second-line options for short term treatment of acute exacerbations in patients with chronic low back pain. As per the documentation submitted, the patient continuously utilized this medication. Despite ongoing use, the patient continued to report severe lower back pain. The patient's physical examination continued to reveal palpable muscle spasm. Additionally, guidelines do not recommend long term use of this medication. Therefore, the request is noncertified.

Zolpidem Tartate 10 mg: 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).

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 Section.

Decision rationale: The Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. There is no documentation of chronic insomnia or sleep disturbance. Additionally, it was noted on 11/20/2013 and 10/23/2013, by [REDACTED] the patient was utilizing Lunesta for insomnia treatment. There is no indication of a failure to respond to nonpharmacologic treatment prior to the initiation of a prescription product. Based on the clinical information received, the request is noncertified.