MAXIMUS Federal Services

Case Number:	CM14-0000999		
Date Assigned:	01/22/2014	Date of Injury:	12/30/2009
Decision Date:	11/03/2014	UR Denial Date:	12/11/2013
Priority:	Standard	Application Received:	01/03/2014

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 and Rehabilitation, has a subspecialty in Interventional Spine 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 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 patient is a 66-year-old male with a date of injury of 12/30/2009. The listed diagnoses per [redacted] are: 1. Status post L3-L4 fusion with [redacted], marked scoliosis. 2. Chronic lumbar radiculitis. 3. Lumbar post laminectomy syndrome. 4. Intractable pain. 5. Diabetes. According to progress report 08/27/2014, the patient complains of low back pain that radiates into the posterior thighs. The patient underwent L3-L4 fusion in 2001 with some improvement. However, the patient's low back pain and radiation to the lower extremity has been worsening. He complains that his legs give way and there is continued weakness. The patient's pain is improved with medications and the pain was rated as a 4/10. It was noted the patient utilizes an electric wheelchair/scooter. Examination revealed marked lateral scoliosis, L3-L4 pedicle screws, fused. L4-L5 has severe stenosis with 7-mm lateral subluxation with right L4 neuroforaminal compression. CT myelogram revealed L4-L5 and L5-S1 severe stenosis. The request is for a motorized scooter/wheelchair and refill of medications. Utilization review denied the request on 09/16/2014. Treatment reports from 01/29/2014 through 08/27/2014 were reviewed.

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 cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines motorized scooter/wheelchair Page(s): 99.

Decision rationale: This patient presents with chronic low back pain that radiates into the posterior thighs. The request is for a motorized scooter/wheelchair. For power mobility devices, the MTUS Guidelines page 99 has the following "not recommended if the functional mobility deficits 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 assistant with the manual wheelchair." Report 01/29/2014 indicates that the patient is already utilizing an electric scooter/wheelchair, as he has difficulty standing with progressive leg weakness. Reports continually note that the patient is utilizing a motorized wheelchair or scooter. The medical file does not discuss a request for motorized scooter/wheelchair and the Request for Authorization does not include this request. It appears the patient is already utilizing a motorized scooter/wheelchair. Furthermore, there is no documentation of upper extremity problems where a manual wheelchair cannot be considered. The request is not medically necessary.

Butrans Patches: 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 Criteria for use of opioids MTUS, on-going management Page(s): 88 and 89; 78.

Decision rationale: This patient presents with chronic low back pain that radiates into the posterior thighs. The treating physician is requesting a refill of Butrans patch. For opiate management, MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior). Review of the medical file indicates the patient has been prescribed these patches since 01/29/2014. The treating physician assesses the patient's pain utilizing a pain scale and continually notes improvement in pain with current medications. Although the treating physician has noted that medications improve pain, he does not list or discuss specific functional changes with utilizing this medication. Furthermore, there are no urine drug screens to monitor compliance of medication as required by MTUS for chronic opioid use. Given the lack of sufficient documentation for opiate management, the request is not medically necessary.

Oxycodone 10/325: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: Chronic Pain Medical Treatment Guidelines, Opioids

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines on-going management, Criteria for use of opioids Page(s): 88 and 89; 78.

Decision rationale: This patient presents with chronic low back pain that radiates into the posterior thighs. The treater is requesting a refill of Oxycodone 10/325mg. For opiate management, MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior). Review of the medical file indicates the patient has been prescribed these patches since 01/29/2014. The treating physician assesses the patient's pain utilizing a pain scale and continually notes improvement in pain with current medications. Although the treating physician has noted that medications are helping, he does not list or discuss specific functional changes with utilizing this medication. Furthermore, there are no urine drug screens to monitor compliance of medication as required by MTUS for chronic opioid use. Given the lack of sufficient documentation for opiate management, the request is not medically necessary.

Cyclobenzaprine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines cyclobenzaprine Page(s): 64.

Decision rationale: This patient presents with chronic low back pain that radiates into the posterior thighs. The MTUS page 64 states that cyclobenzaprine is recommended for a short course of therapy. Limited mixed evidence does not allow for recommendation for chronic use. Review of the medical file indicates that the patient has been prescribed Cyclobenzaprine since 01/29/2014. In this case, this medication is not recommended to be used for longer than 2-3 weeks. The request is not medically necessary.

Zolpidem Tartrate 10mg: 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) Chronic pain chapter, Insomnia treatment

Decision rationale: This patient presents with chronic low back pain that radiates into the posterior thighs. The patient has been continually taking Lunesta since 01/29/2014. On 08/27/2014, the treating physician recommended Ambien 10 mg stating that the patient has poor quality of sleep. The MTUS and ACOEM Guidelines do not address Ambien. However, ODG Guidelines under its pain section states that Zolpidem (Ambien) is indicated for short-term treatment of insomnia with difficulty of sleep onset 7 to 10 days. The treating physician is attempting a trial of Ambien as the patient has been taking Lunesta with continued sleep issues. Although a trial maybe indicated, the treater is requesting #30 and Ambien is not recommended for long term use. The request is not medically necessary.