

Case Number:	CM14-0104271		
Date Assigned:	07/30/2014	Date of Injury:	09/17/2003
Decision Date:	10/27/2014	UR Denial Date:	06/21/2014
Priority:	Standard	Application Received:	07/07/2014

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 Preventative Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This patient is a 46 year old employee with date of injury of 9/17/2003. Medical records indicate the patient is undergoing treatment for chronic low back pain. Subjective complaints include back pain that waxes and wanes. He takes Norco 10-325 mg 6 per day for pain. He finds Theracane helpful. Objective findings include in the lumbar back he has tenderness to palpation in the right and left muscles over the SI joint bilaterally with definite tender lump trigger point identified. He has decreased range of motion and stiffness. He has difficulty making transitions and transfers stiffly. His gait is normal. Treatment has consisted of TENS unit, acupuncture trigger point treatment, Norco, marijuana club card, Theracane, Morphine SR, Ibuprofen, Gabapentin, Amitriptyline and Hydrocodone-Acetaminophen. The utilization review determination was rendered on 6/21/2014 recommending non-certification of 1 STAIRLIFT DEVICE PURCHASE OR RENTAL FOR AT LEAST 1 YEAR; IBUPROFEN 800MG; for HYDROCODONE/ACETAMINOPHEN 10/325 MG; AMITRIPTYLINE 25 MG and A PAIN MANAGEMENT PROGRAM.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 STAIRLIFT DEVICE PURCHASE OR RENTAL FOR AT LEAST 1 YEAR: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Durable Medical Equipment (DME) and Exercise Equipment Other Medical Treatment Guideline or Medical Evidence: Medicare.gov, durable medical equipment

Decision rationale: MTUS and ACOEM are silent regarding the medical necessity of a stairlift. ODG does state regarding durable medical equipment (DME), "Recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME) below" and further details "Exercise equipment is considered not primarily medical in nature". Medicare details DME as: -durable and can withstand repeated use-used for a medical reason-not usually useful to someone who isn't sick or injured-appropriate to be used in your home While the treating physician does document that stairs exacerbated the patient's low back pain, the treating physician did not provide clinical documentation of severe disability to justify a stair lift at this time. In addition, medical documents note that the patient was able to utilize stairs and had a normal gait. As such, the request for is not 1 stairlift device purchase or rental for at least 1 year medically necessary.

IBUPROFEN 800MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ibuprofen, NSAIDs, Page(s): 67-72.

Decision rationale: MTUS recommends the use of NSAIDS for the acute exacerbation of back pain at the lowest effective dose for the shortest amount of time due to the increased cardiovascular risk, renal, hepatic and GI side effects associated with long term use. MTUS states "Ibuprofen (Motrin, Advil [otc], generic available): 300, 400, 600, 800 mg. Dosing: Osteoarthritis and off-label for ankylosing spondylitis: 1200 mg to 3200 mg daily. Individual patients may show no better response to 3200 mg as 2400 mg, and sufficient clinical improvement should be observed to offset potential risk of treatment with the increased dose. Higher doses are generally recommended for rheumatoid arthritis: 400-800 mg PO 3-4 times a day, use the lowest effective dose. Higher doses are usually necessary for osteoarthritis. Doses should not exceed 3200 mg/day. Mild pain to moderate pain: 400 mg PO every 4-6 hours as needed. Doses greater than 400 mg have not provided greater relief of pain". Long term use of NSAIDS is not recommended. The treating physician did not document a decrease in pain or functional improvement from the use of Ibuprofen. As such the request for Ibuprofen 800mg is not medically necessary.

HYDROCODONE/ACETAMINOPHEN 10/325 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone page 51, Opioids Page(s): 74-95. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Opioids, Pain

Decision rationale: ODG does not recommend the use of opioids for low back pain "except for short use for severe cases, not to exceed 2 weeks." The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "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." The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. Additionally, the patient expressed a desire to stop hydrocodone use. As such, the question for Norco 325/10mg is not medically necessary.

AMITRIPTYLINE 25 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain Page(s): 13. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, TCA's

Decision rationale: MTUS states that "Amitriptyline is a tricyclic antidepressant. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated." ODG states "Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Side effects, including excessive sedation (especially that which would affect work performance) should be assessed. (Additional side effects are listed below for each specific drug.) It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. The optimal duration of treatment is not known because most double-blind trials have been of short duration (6-12 weeks). It has been suggested that if pain is in remission for 3-6 months, a gradual tapering of anti-depressants may be undertaken." ODG states "Dosing Information: Amitriptyline: Neuropathic pain: The starting dose may be as low as 10-25 mg at night, with increases of 10-25 mg once or twice a week up to 100 mg/day. (ICSI, 2007) The lowest effective dose should be used (Dworkin, 2007)." The treating physician has not met the above guidelines to utilize Amitriptyline. The treating physician provided no evidence of recent neuropathic pain and depression. As such, the request for Amitriptyline 25mg is not medically necessary.

PAIN MANAGEMENT PROGRAM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic
pain program Page(s): 30-34. Decision based on Non-MTUS Citation Official Disability
Guidelines (ODG) Pain, Chronic Pain Programs

Decision rationale: MTUS states, "Criteria for the general use of multidisciplinary pain management programs: Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed." ODG states concerning chronic pain programs "(e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function." While the treating physician does document the use of opioids, the treating physician has not provided detailed documentation of chronic pain treatment trials and failures to meet all six MTUS criteria for a chronic pain management program. As such the request for COMPREHENSIVE PAIN MANAGEMENT ASSESSMENT is not medically necessary.