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| Case Number: | CM14-0056321 | | |
| Date Assigned: | 07/16/2014 | Date of Injury: | 10/28/1993 |
| Decision Date: | 08/29/2014 | UR Denial Date: | 04/18/2014 |
| Priority: | Standard | Application Received: | 04/26/2014 |

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 & Rehab, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 10/28/1993. The mechanism of injury was not provided for review. The injured worker reportedly sustained an injury to his neck, shoulder, bilateral wrists, and low back. The injured worker ultimately developed chronic pain syndrome. The injured worker ultimately underwent fusion surgery that resulted in partial fusion at the C2-3. The injured worker's medications included OxyContin 80 mg, Oxycodone 30 mg, Marionol 5 mg, and Nexium 40 mg. The injured worker was evaluated on 02/11/2014. It was noted that the injured worker complained of feelings of paralysis on the left side of his body. No physical findings were provided for that examination as the report was incomplete. The injured worker was evaluated on 01/07/2014. Physical findings included decreased grip strength of the right upper extremity with tenderness to palpation of the lumbar, thoracic and cervical spine. The injured worker's diagnoses included cervical spine sprain/strain, right shoulder sprain/strain, bilateral carpal tunnel syndrome, thoracolumbar sprain/strain, lumbar sprain/strain, lumbar disc bulging, right knee sprain/strain, Crohn's disease, and chronic pain syndrome. The injured worker's most recent clinical evaluation was dated 04/07/2014. However, there was no change in the information provided from the previous appointment. At that appointment, a request was made for acupuncture and a therapeutic dog and a refill of medications. A request was made for a prescription of Marionol, additional acupuncture, a Moji roller massager, a Tempurpedic queen size bed, an ergo system grand ergo base, a Moji neck and heat wrap, and a Shiatsu chair massage pad.

IMR ISSUES, DECISIONS AND RATIONALES

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

Marionol 5MG (NO SIG LISTED): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cannabinoids Page(s): 28.

Decision rationale: The requested Marionol 5 mg is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not support the use of medical marijuana. It is noted that there are very few controlled studies to support the efficacy and safety and long-term use of this medication over more traditional treatments. Additionally, the request as it is submitted does not identify a frequency of treatment or quantity. In the absence of this information, the appropriateness of the request itself cannot be determined.

Acupuncture X6 Sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The requested acupuncture x6 sessions is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends ongoing treatment with acupuncture based on documented functional benefit, symptom relief, and reduction of medications. The clinical documentation submitted for review does not provide any objective quantifiable evidence to support the efficacy of previous treatments. Therefore, additional treatments would not be indicated. Furthermore, the request as it is submitted does not clearly identify an applicable body part for treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested acupuncture x6 sessions is not medically necessary or appropriate.

Moji 360 Roller Massage: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; DME Equipment Terminology Description.

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, Durable Medical Equipment (DME).

Decision rationale: The requested Moji 360 roller massage is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not specifically address durable medical equipment. The Official Disability Guidelines recommend the use of

durable medical equipment that is primarily used to serve a medical purpose. It is also recommended that durable medical equipment not be useful to the injured worker in the absence of injury or illness. The requested roller massage does not meet the criteria. Additionally, Official Disability Guidelines recommend durable medical equipment be rented. The request as it is submitted does not clearly identify if the request is for purchase or rental. As such, the requested Moji 360 roller massage is not medically necessary or appropriate.

Tempur Pedic Grand Bed Queen Size: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, DME Equipment, Specialized Mattress Or Bedding; Low Back, Mattress Selection.

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, Durable Medical Equipment and Low Back Chapter, Mattress Selection.

Decision rationale: The requested Tempurpedic grand bed queen size is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this request. The Official Disability Guidelines do not support the use of mattress selection as medical treatment for back injuries. Additionally, the Official Disability Guidelines recommend that durable medical equipment be appropriate when it is primarily used to serve a medical purpose and is not useful to the injured worker in the absence of injury or illness. The clinical documentation does not provide any justification to support the need of this type of equipment. Furthermore, as it is not supported by guideline recommendations it would not be indicated in this clinical situation. As such, the requested Tempurpedic grand bed queen size is not medically necessary or appropriate.

Ergo System Grand Ergo Base: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, DME Equipment, Specialized Mattress Or Bedding.

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, Durable Medical Equipment.

Decision rationale: The requested ergo system grand ergo base is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not specifically address durable medical equipment. The Official Disability Guidelines recommend the use of durable medical equipment that is primarily used to serve a medical purpose. It is also recommended that durable medical equipment not be useful to the injured worker in the absence of injury or illness. The requested roller massage does not meet the criteria. Additionally, Official Disability Guidelines recommend durable medical equipment be rented. The request as

it is submitted does not clearly identify if the request is for purchase or rental. As such, the requested ergo system grand ergo base is not medically necessary or appropriate.

Moji Neck And Heat Wrap: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183.

Decision rationale: The requested Moji neck and heat wrap is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine do recommend heat and cold applications for neck injuries. However, the clinical documentation does not provide any justification for specialized equipment over more traditional neck and heat wraps. As such, the requested Moji neck and heat wrap is not medically necessary or appropriate.

Shiatsu Chair Massage Pad: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines,, Knee & Leg Chapter, DME (Durable Medical Equipment) definition.

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

Decision rationale: The requested Shiatsu chair massage pad is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not specifically address durable medical equipment. The Official Disability Guidelines recommend the use of durable medical equipment that is primarily used to serve a medical purpose. It is also recommended that durable medical equipment not be useful to the injured worker in the absence of injury or illness. The requested roller massage does not meet the criteria. Additionally, Official Disability Guidelines recommend durable medical equipment be rented. The request as it is submitted does not clearly identify if the request is for purchase or rental. As such, the requested Shiatsu chair massage pad is not medically necessary or appropriate.