

Case Number:	CM14-0087853		
Date Assigned:	08/18/2014	Date of Injury:	01/13/2009
Decision Date:	09/29/2014	UR Denial Date:	05/14/2014
Priority:	Standard	Application Received:	06/11/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 64 year old female who sustained an injury on 01/13/09 when she was involved in a motor vehicle accident. The injured worker is noted to have undergone a prior lumbar fusion at L4-5 followed by hardware removal. The injured worker also underwent a minimally invasive left sacroiliac joint fusion as well as a prior left shoulder arthroscopic decompression with a rotator cuff repair performed in July of 2009. The injured worker recently underwent a left knee replacement in August of 2013. There were noted concerns regarding possible infection of the prosthetic implants in the left knee. As of 04/11/14, the injured worker continued to complain of generalized fatigue with warmth in the left knee. It is noted on laboratory studies that the injured worker had an elevated sedimentation rate as well as a white blood cell count. Urinalysis and blood cultures were negative for evidence of infection. Medications continued at this evaluation included Wellbutrin XL 150mg, Lexapro 10mg, Amitiza 24mcg, Dexilant 60mg, Ranitidine 150mg, Peri-Colace, Ambien 10mg, Topamax for headaches, Qvalaquin, and Oxycontin 10mg. The injured worker did undergo polysomnography studies on 05/05/14 which noted low sleep efficiency secondary to pain. There was no clear diagnosis of insomnia or obstructive sleep apnea. As of 05/27/14, the injured worker did have decreased warmth in the left knee; however, she continued to report severe fatigue with an elevated sedimentation rate. Physical examination continued to note warmth, although decreased in the left knee. There was continuing restricted range of motion in the cervical spine. The medications were updated with quantities at this evaluation. The injured worker was again recommended to follow up with an orthopedist regarding her frozen right shoulder. The requested continued home care assistance for 6 hours a day, 7 days a week as well as Wellbutrin 150mg, Lexapro 10mg, Amitiza 24mcg, Dexilant 60mg, Ranitidine 150mg, Ambien 10mg,

Topamax, Oxycontin 10mg, and Qualaquin 324mg were all denied by utilization review on 05/14/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continued Home Care Assistance (6 Hours/Day, 7 Days/Week): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Home-Health Services.

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 Chapter, Home Health.

Decision rationale: In regards to the requested continued home care assistance for 6 hours a day, 7 days a week, the clinical documentation submitted for review did not provide any ongoing documentation regarding continued requirements for home care assistance. The injured worker is noted to be fatigued with limited range of motion present in the right shoulder. The clinical documentation submitted for review did not provide any further discussion regarding the injured worker's home health care needs. It is unclear whether there are any other family members who could provide a reasonable level of care for the injured worker. No home health care reports were available for review documenting ongoing restrictions to the extent where the injured worker would not be able to reasonably take care of herself. Given the limited information regarding the injured worker's continued home health care requirements, the request is not medically necessary and appropriate.

Wellbutrin 150mg (QTY UNKNOWN): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13,16.

Decision rationale: The clinical documentation submitted for review did not clarify the quantity, frequency, or duration of this medication. Given the insufficient documentation regarding the requested amount, the frequency of this medication, or its expected duration, the request is not medically necessary and appropriate.

Lexapro 10mg (QTY UNKNOWN): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-16.

Decision rationale: The clinical documentation submitted for review did not clarify the quantity, frequency, or duration of this medication. Given the insufficient documentation regarding the requested amount, the frequency of this medication, or its expected duration, the request is not medically necessary and appropriate.

Amitiza 24mcg (QTY UNKNOWN): 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 Opioids Page(s): 88-89.

Decision rationale: The clinical documentation submitted for review did not clarify the quantity, frequency, or duration of this medication. Given the insufficient documentation regarding the requested amount, the frequency of this medication, or its expected duration, the request is not medically necessary and appropriate.

Dexilant 60mg (QTY UNKNOWN): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton-Pump Inhibitors.

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

Decision rationale: The clinical documentation submitted for review did not clarify the quantity, frequency, or duration of this medication. Given the insufficient documentation regarding the requested amount, the frequency of this medication, or its expected duration, the request is not medically necessary and appropriate.

Ranitidine 150mg (QTY UNKNOWN): 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) Pain Chapter, proton pump inhibitors.

Decision rationale: The clinical documentation submitted for review did not clarify the quantity, frequency, or duration of this medication. Given the insufficient documentation

regarding the requested amount, the frequency of this medication, or its expected duration, the request is not medically necessary and appropriate.

Ambien 10mg (QTY UNKNOWN): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Sleep Aid.

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

Decision rationale: The clinical documentation submitted for review did not clarify the quantity, frequency, or duration of this medication. Given the insufficient documentation regarding the requested amount, the frequency of this medication, or its expected duration, the request is not medically necessary and appropriate.

Topamax (QTY UNKNOWN): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Seizure Medication for the Treatment of Neuropathic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-convulsants Page(s): 16-22.

Decision rationale: The clinical documentation submitted for review did not clarify the quantity, frequency, or duration of this medication. Given the insufficient documentation regarding the requested amount, the frequency of this medication, or its expected duration, the request is not medically necessary and appropriate.

Oxycontin 10mg (QTY UNKNOWN): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 88-89.

Decision rationale: The clinical documentation submitted for review did not clarify the quantity, frequency, or duration of this medication. Given the insufficient documentation regarding the requested amount, the frequency of this medication, or its expected duration, the request is not medically necessary and appropriate.

Qualaquin 324 mg (QTY UNKNOWN): 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 Other Medical Treatment Guideline or Medical Evidence: Quaalun. (2013). In Physicians' desk reference 67th ed.

Decision rationale: The clinical documentation submitted for review did not clarify the quantity, frequency, or duration of this medication. Given the insufficient documentation regarding the requested amount, the frequency of this medication, or its expected duration, the request is not medically necessary and appropriate.