

<b>Case Number:</b>	CM14-0197221		
<b>Date Assigned:</b>	12/19/2014	<b>Date of Injury:</b>	12/04/2006
<b>Decision Date:</b>	01/29/2015	<b>UR Denial Date:</b>	11/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/24/2014

### 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 Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 47 year old male with a work injury dated 12/4/06. The diagnoses include thoracolumbar musculoligamentous sprain/strain with bilateral lower extremity radiculitis; multilevel degenerative disc disease and neuroforaminal stenosis; cervical/trapezial musculoligamentous sprain/strain with multilevel degenerative disc disease and stenosis. Under consideration are requests for Norco 10/325mg #120; Ativan 2mg #30; transportation to and from all appointments/visits; home care assistance. An 11/24/14 PR-2 report states that the patient has increased low back pain and increased numbness/tingling radiating to the bilateral lower extremities since he is unable to use his home electrical muscle stimulation unit as it is no longer functioning and replacement was not authorized. His pain is moderate to severe and worsening. On exam he ambulates with crutches. The lumbar spine reveals tenderness to palpation with muscle guarding and muscle spasm over the paravertebral muscles to the lumbosacral junction. The straight leg raise is positive bilaterally eliciting radicular symptoms to the bilateral L5-S1 nerve root. Sensation to pinprick and light touch is decreased. His current medications include Norco, Ativan, and Colace which he has an adequate supply of. Pain with meds 4/10 and without meds 8/10. This helps him perform a home exercise program and ADLs. The treatment plan includes a request for authorization for continued home care assistance 5 hours/day for 7 days a week for six weeks; transportation to and from all medical appointments. The patient is temporarily totally disabled. The plan includes authorization for a surgical consult; updated MRI; replacement TENS.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78-80.

**Decision rationale:** Norco 10/325mg #120 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS Chronic Pain Medical Treatment Guidelines state that a 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 MTUS does not support ongoing opioid use without improvement in function or pain. The documentation submitted reveals that the patient has been on long term opioids without significant functional improvement and prior reviews recommending weaning. Therefore the request for Norco 10/325mg #120 is not medically necessary.

**Ativan 2mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** Ativan 2mg #30 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. The documentation indicates that the patient has been on Ativan significantly longer than the 4 week recommended time period. There are no extenuating circumstances requiring continued use. The request for Ativan 2mg #30 is not medically necessary.

**Transportation to and from all appointments/visits:** 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) Knee and Leg-Transportation (to & from appointments).

**Decision rationale:** Transportation to and from all appointments/visits is not medically necessary per the ODG Guidelines. The MTUS does not directly address this request. The ODG states that transportation is recommended for medically-necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport. The ODG states that this reference applies to patients with disabilities preventing them from self-transport who are age 55 or older and need a nursing home level of care. Transportation in other cases should be agreed upon by the payer, provider and patient, as there is limited scientific evidence to direct practice. The request as written asks for transportation to all appointments and visits which implies more than just medical visits. This request is not purely a medical request and is outside the scope of pure medical necessity review. For these reasons the request for transportation to and from all appointments/visits is not medically necessary.

**Home care assistance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare Benefits Manual (Rev.144,05-05-11) Chapter 7-home health services; section 50.2 (home health aide services)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

**Decision rationale:** Home care assistance is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that home health is recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. The request does not indicate a number of hours per week and the documentation is not clear that the patient is homebound. Home care assistance is not medically necessary.