MAXIMUS Federal Services

Case Number:	CM14-0205799		
Date Assigned:	12/17/2014	Date of Injury:	03/12/2012
Decision Date:	02/28/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	12/09/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 46-year-old female with an injury date of 03/12/2012. Based on the 08/20/2014 progress report, the patient complains of severe pain in her lumbar spine, which radiates into her lower extremities. She also has weakness in her lower extremities. The patient has progressive weakness, risk of falls, loss of function in legs, and deterioration of gait and balance. The 09/17/2014 report indicates that the patient has lumbar spine pain with radiation to the lower extremities. No positive exam findings are provided on this report. The 10/23/2014 report states that the patient has lumbar spine pain with bilateral radiculopathy. She states that her legs will give out, causing her to fall. The 10/23/2014 report states that the patient has left-sided weakness on her lumbar spine. The patient has decreased sensation in the left FA. The patient's diagnoses include the following:Thoracic/lumbosacral neuritis, unspecified.Spinal stenosis, lumbar spine.Post-laminectomy syndrome, lumbar region. Acquired spondylolisthesis. Degenerative intervertebral disk.Spinal stenosis, cervical region. The utilization review determination being challenged is dated 11/18/2014. Treatment reports are provided from 03/06/2014-10/23/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic) Chapter, Zolpidem

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

Decision rationale: The patient presents with lumbar spine pain and bilateral radiculopathy. The request is for Ambien. The patient has been taking Ambien as early as 08/20/2014. MTUS and ACOEM Guidelines are silent with regard to this request. However, ODG Guidelines, mental illness and stress chapter, zolpidem (Ambien) states, "Zolpidem (Ambien, generic available, Ambien CR) is indicated for short-term use of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Long-term studies have found Ambien CR to be effective for up to 24 weeks in adults." ODG Guidelines support the use of Ambien for 7 to 10 days for insomnia. The patient has been taking Ambien since 08/20/2014, which is indicated to be on a long-term basis and is not recommended by ODG Guidelines. Furthermore, there is no indication that the patient has insomnia with difficulty of sleep onset. Therefore, the requested Ambien is not medically necessary.

Home health care 8 hours a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines home service Page(s): 51.

Decision rationale: The patient presents with lumbar spine pain and bilateral radiculopathy. The request is for home healthcare 8 hours a week for 4 weeks. The report with the request is not provided. MTUS Guidelines, page 51, has the following regarding home service, "Recommended only for otherwise recommended medical treatments 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, laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed." There are no discussions provided regarding this request, nor is there a report with the request provided. The treater states that the patient has progressive weakness, risk of falls, loss of function in legs, and deterioration of gait and balance but does not provide an organic basis for such deficits other than from chronic pain and deconditioning. There is no paralysis, significant neurologic deficits, or functional loss to prevent this patient from self-care and performing the necessary ADLs. The patient does not present with any organic basis for inability to perform home duties. The requested home healthcare 8 hours a week for 4 weeks is not medically necessary.