

<b>Case Number:</b>	CM15-0015500		
<b>Date Assigned:</b>	02/03/2015	<b>Date of Injury:</b>	11/17/2009
<b>Decision Date:</b>	05/15/2015	<b>UR Denial Date:</b>	12/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/27/2015

### 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, Illinois

Certification(s)/Specialty: Internal Medicine

### 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 42 year old male with a sustained work related injury dated 11/17/2009. The mechanism of injury was not stated. The current diagnoses include lumbar spine stenosis, lumbar discopathy, left knee osteoarthritis, right knee patellar tendinitis, status post laminectomy at T11-12 on 07/12/2011, status post thoracic fusion on 07/19/2011, extension of laminectomy on 07/23/2011, thoracic wound debridement on 08/20/2011, diffuse thoracic spine stenosis and hemiparesis, thoracic hardware infection, bilateral shoulder impingement, bilateral upper extremity tendonitis, and panthoracic spinal stenosis. The injured worker presented on October 21, 2014 for a follow-up evaluation. The injured workers chief complaint was draining abscess from prior back surgery, urinary incontinence and having to straight catheterization. It was noted that the injured worker utilized a condom catheter. According to progress note of the physical exam noted a draining abscess from prior spinal surgery. The injured worker was on oral antibiotics. The injured worker was also wheelchair bound and had frequent urinary tract infections. The primary treating physician requested authorization for one wound care consult and one home care 24hours/day 7days per week, on electric scooter, prescription for Norco 10mg #60 and Ambien 10mg #30. A Request for Authorization Form was submitted on 12/18/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Wound care consultation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 296. Decision based on Non-MTUS Citation Official Disability Guidelines; Infectious diseases.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. In this case, it does not appear that a wound care consultation is indicated at this time. Although it is noted that the injured worker has a thoracic and right foot wound, the injured worker has been issued authorization for a consultation with a spine surgeon as well as a podiatrist. The concurrent request for a consultation to address thoracic spine and right foot wounds was authorized in 12/2014. The medical necessity for the current request has not been established in this case. As such, the request is not medically appropriate.

**Home care 24hrs./7 days:** 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, 05/06/2011) Chapter 7; Home health Services.

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

**Decision rationale:** California MTUS Guidelines recommend home health services only for otherwise recommended medical treatment for patients who are homebound on a part time or intermittent basis. Home health services are generally recommended for up to no more than 35 hours per week. The current request for home care on a 24-hour basis for 7 days per week exceeds guidelines' recommendations. The specific type of services required were not listed. Given the above, the request is not medically appropriate at this time.

**Electric Scooter with car lift:** 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 Page(s): 99.

**Decision rationale:** California MTUS Guidelines do not recommend power mobility devices if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or a walker, or the patient has sufficient upper extremity function to propel a manual wheelchair. In

this case, it is noted that the injured worker is wheelchair bound at this time. However, the documentation submitted failed to indicate evidence of an upper extremity functional deficit prohibiting the use of a manual wheelchair. Given the above, the request is not medically appropriate at this time.

**Norco 10mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized the above medication for an unknown duration. There is no documentation of objective functional improvement. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.

**Ambien 10mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Zolpidem (Ambien). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Insomnia Treatment.

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

**Decision rationale:** The Official Disability Guidelines recommend insomnia treatment based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. In this case, there was no documentation of a failure to respond to nonpharmacologic treatment prior to the initiation of a prescription product. There is no mention of functional improvement despite the ongoing use of this medication. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.