

<b>Case Number:</b>	CM15-0138009		
<b>Date Assigned:</b>	07/27/2015	<b>Date of Injury:</b>	02/13/2006
<b>Decision Date:</b>	09/24/2015	<b>UR Denial Date:</b>	07/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/16/2015

### 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, Massachusetts

Certification(s)/Specialty: Preventive Medicine, Occupational 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 51 year old male, who sustained an industrial injury on 2/13/2006. Diagnoses include post cervical decompression, pending surgical recommendation for C6-7 fusion and peripheral neuropathy. Treatment to date has included surgical intervention (recent revision anterior cervical discectomy and fusion (ACDF) C6-7), as well as conservative measures including medication management. Current medications include Cymbalta, Gabapentin, Lunesta, Lyrica, Norco, Dilauded, Diazepam, Glyburide, Metformin, Lisinopril, Humulin and Seroquel. Per the Primary Treating Physician's Progress Report dated 6/18/2015, the injured worker reported neck pain, lower back pain and bilateral leg pain. He reports five recent falls since the last visit and significant worsening of his symptoms since his recent ACDF surgery. Physical examination revealed limited cervical range of motion due to fusion. There was tenderness of the lumbar spine over the quadratus lumborum and axial spine with decreased range of motion due to pain. The plan of care included, and authorization was requested, for one three wheel recumbent bike, Gabapentin, Dilauded, Norco, Diazepam, 6 months of home health care (4x7) and unknown sessions of water therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One 3 wheel recumbent bike:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg (Acute & Chronic) Durable medical equipment (DME). 2015.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): s 46-47.

**Decision rationale:** A recumbent bike is not indicated as a physical medical intervention as it is not part of a set treatment plan that is prescribed and followed by a medical professional. As well there is no indication that the recumbent bike will provide clinically necessary physical activity that is better or different than other physical activities. Lacking the clinical necessity and guidelines, this request is not medically necessary at this time.

**Dilaudid 4mg, #200:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 76-96.

**Decision rationale:** CA MTUS guidelines require that criteria for continued long-term use of opioids require ongoing review and documentation of pain relief, functional status improvement, appropriate use, screening of side effects and risk for abuse, diversion and dependence. From my review of the provided medical records there is lacking a description of quantifiable improvement with ongoing long-term use of short acting opioids such as the prescribed medication. VAS score has stayed unchanged with no noted improvement in objective physical exam findings or functional capacity. Additionally the recommended upper dosage limit is 120 mg MED; the current prescription is well above the recommended safe dosage level. Consequently continued use of short acting opioids is not supported by the medical records and guidelines. The request is not medically necessary at this time.

**Diazepam 10mg, #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:** According to the MTUS guidelines, benzodiazepines such as the above medication is 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 week. Additionally, the guidelines state that tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. The patient has been on this specific benzodiazepine medication for more than

4 weeks and there is no cited efficacy in the provided medical records to support continued use. Consequently the medical records and cited guidelines do not support continued use of this medication at this time. The request is not medically necessary.

**Six months of home health care for 4 hr a day, 7 days a 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, Pain (chronic) Home Health Services, 2015.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health care Page(s): 42.

**Decision rationale:** While home health services are indicated for this patient based on impairment of functioning and lack of independence of ADL, the current request for 6 months is beyond the time duration of the cited guidelines and recommendation is to initiate a shorter course followed by in house assessment to determine the needs for continued home health care services.

**Unknown sessions of water therapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 94, Chronic Pain Treatment Guidelines Aquatic therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): s 46-47.

**Decision rationale:** While hydrotherapy is appropriate, based on the guidelines, if land therapy is not effective or unreasonable, it is only recommended under clear guidelines of duration and under the direction of a trained therapist/trainer. The current request is for unknown sessions of hydrotherapy under what is unclear direction. Based on the lack of supporting clinic evidence outlying the directions of care including duration of therapy and physical objectives, the requested therapy is not recommended. The request is not medically necessary.