MAXIMUS Federal Services

Case Number:	CM15-0165343		
Date Assigned:	09/02/2015	Date of Injury:	04/21/2008
Decision Date:	10/22/2015	UR Denial Date:	07/31/2015
Priority:	Standard	Application Received:	08/24/2015

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, Arizona
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 injured worker is a 67 year old female, who sustained an industrial injury on 4-21-08. The injured worker has complaints of mid and low back pain radiating to the left lower extremity and right wrist and hand pain. The pain quality is sharp along with tenderness, tingling and sensitivity to touch about the lumbar region is also noted, with radiating pain felt on left lumbar region going down left leg to knee and ankle region described as sharp in quality. The diagnoses have included thoracic sprain and strain; lumbar sprain and strain; status post lumbar spine surgery and right wrist sprain and strain. Comprehensive physical exam performed 05/18/2015 was also reviewed showing on examination diffuse paralumbar tenderness, with L3-4 myotomal and L4 dermatomal dysfunction and positive straight leg raise testing. Treatment to date has included lumbar surgery in 2012 on L4 and L5; hydrocodone; percocet; ibuprofen; lidoderm patches; Pepcid and home exercise program. The request was for 1 follow-up office visit in 4-6 weeks, thoracic and lumbar spine and right wrist; ambien 10mg #30; restoril 30mg #30 and heating pad, low pack quantity one.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Follow-up office visit in 4-6 weeks, thoracic/ lumbar spine and right wrist: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Follow up visits.

Decision rationale: The CA MTUS Guidelines, ACOEM Guidelines recommend a consultation to aid with diagnosis/prognosis and therapeutic management, recommend referrals to other specialists if a diagnosis is uncertain or exceedingly complex when there are psychosocial factors present, or when a plan or course of care may benefit from additional expertise. In this case, the injured worker has worsening low back pain that has not responded to medical treatments, physical therapy, or a course of acupuncture in the recent past. The Official Disability Guidelines state that the need for a clinical office visit with a healthcare provider is individualized based on a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. Additional expertise and/or close follow up with her primary treating providers as it pertains to her chronic back pain is reasonable and as such, this request is medically necessary.

Ambien 10mg #30: 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), Zolpidem (Ambien). updated 7/15/15 online version.

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

Decision rationale: According to the Official Disability Guidelines (ODG), Ambien is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. They are not recommended for long-term use. They can be habit-forming and impair function and memory more than opioid pain relievers. Within the submitted documentation there are no extenuating factors described to warrant non-adherence to guideline recommendations. As such, the request for Ambien is not medically necessary.

Restoril 30mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

Decision rationale: California MTUS guidelines state that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there are risks of dependency. Guidelines generally limit use to 4 weeks. Chronic benzodiazepines are the treatment of choice in very few conditions. Temazepam is a benzodiazepine used to treat insomnia. There is no clear mention of why the injured worker is needing both Temazepam and Ambien, both of which were prescribed. Long-term use is not recommended. No extenuating factors were described to warrant non-adherence to guideline recommendations. As such, this request is not medically necessary.

Heating pad, low pack. Qty: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Cold/heat packs.

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, Heat/Cold Packs.

Decision rationale: Occupational Medicine Practice Guidelines state that various modalities such as heating have insufficient testing to determine their effectiveness, but they may have some value in the short term if used in conjunction with a program of functional restoration. ODG states that heat/cold packs are recommended as an option for acute pain. Within the submitted documentation available for review, it appears the injured worker has chronic pain with acute flares. However, there is no mention of heating pads being used as an adjunct to a program of functional restoration. Physical therapy is still pending. There is no mention of a home program. Without clarification of the mentioned issues, the request for a heating pad is not medically necessary.