

Case Number:	CM15-0198666		
Date Assigned:	11/06/2015	Date of Injury:	10/07/1983
Decision Date:	12/28/2015	UR Denial Date:	09/15/2015
Priority:	Standard	Application Received:	10/09/2015

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, North Carolina Certification(s)/Specialty: Family Practice

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 10-7-83. Medical records indicate that the injured worker is undergoing treatment for bilateral wrist tendinitis, carpal tunnel syndrome, right rotator cuff insufficiency and likely left rotator cuff insufficiency. The injured worker is currently temporarily totally disabled. On (9-2-15) the injured worker complained of constant low back pain rated 10 out of 10 on the visual analog scale. The injured worker also noted bilateral shoulder pain. Objective findings revealed tenderness to palpation, spasm and a decreased range of motion of the shoulders. Lumbar spine examination revealed tenderness to palpation. The injured worker was noted to have difficulty with activities of daily living due to her shoulder pain. The treating physician recommended home health care. The referenced note was handwritten and difficult to decipher. A progress note dated 7-14-15 noted the injured worker pain level to be 7-out of 10 and on 4-22-15 the injured worker pain level was rated 8-9 out of 10 on the visual analog scale. Treatment and evaluation to date has included medications, MRI, right shoulder injections, physical therapy and a home exercise program. Current medications include Ultram ER (since at least November of 2014), Fexmid, Fioricet, temazepam, promethazine, Neurontin, Voltaren and Senna. The Request for Authorization dated 9-2-15 included requests for home care four hours a day for two days and Ultram ER 150mg #60. The Utilization Review documentation dated 9-15-15 non-certified the request for home care four hours a day for two days and modified the Ultram ER 150mg to #45 (original request #60).

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultram ER 150mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The request is for Ultram ER for treatment of chronic low back pain. Ultram (Tramadol) is a centrally-acting synthetic opioid indicated for short-term use in treating moderate to severe pain. Long-term use may be appropriate if there is documented evidence of pain relief and functional improvement. In this case, the claimant reports increased back pain and decreased functional capacity despite the use of Ultram. The claimant's medical regimen involves agents known to potentiate opioid adverse reactions. Thus for the reason above, the request is not medically necessary or appropriate.

Home care for 4 hours a day for 2 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, 05/05/11), Chapter 7 - Home Health Services; section 50.2 (Home Health Aide Services).

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

Decision rationale: CA MTUS Guidelines state that home health services are recommended only for patients who are home bound, on a part-time basis, generally up to no more than 35 hours/week. Home health services should be limited to that needed for medical purposes. In this case, the claimant is not confined to the home. In addition, the treatment plan does not call for PT, OT, skilled nursing or speech pathology that would require home visits. There is no evidence of a significant functional deficit requiring home health services, therefore the request is not medically necessary or appropriate.