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| Case Number: | CM15-0026765 | | |
| Date Assigned: | 02/20/2015 | Date of Injury: | 12/23/2009 |
| Decision Date: | 04/07/2015 | UR Denial Date: | 01/08/2015 |
| Priority: | Standard | Application Received: | 02/12/2015 |

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
 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 38 year old male who sustained a work related injury on December 23, 2009, from lifting, while he worked at a laundry company. He was diagnosed with displacement of lumbar intervertebral disc without myelopathy, degeneration of lumbar intervertebral disc, lumbosacral radiculitis and chronic pain syndrome. Treatments included physical therapy, anti-inflammatory drugs, pain medication, muscle relaxants and anti-depressant medications. Currently, in October 2014, the injured worker complained of ongoing bilateral low back pain with pain radiating in the lower extremities, groins hips, thighs and heels. On January 8, 2015, a request for one prescription of Norco 10/325mg #240 was non-certified by Utilization Review, noting California Medical Treatment Utilization Schedule Guidelines; a request for a motorized wheelchair was modified to a purchase of a manual wheelchair by Utilization Review, noting California Medical Treatment Utilization Schedule Guidelines; a request for Home Health Care was modified to a Home Health Evaluation, times one by Utilization Review, noting the California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines; and a request for a Neurosurgery Re-evaluation with [REDACTED] has been modified to a Neurosurgery Re-evaluation, by Utilization Review, noting the Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: This patient presents with lower back pain, pain in the lower extremities, groin, hips, thighs, and heels. The treater has asked for NORCO 10/325MG #240 on 10/9/14. Patient has been using Norco since 7/3/14 report. For chronic opioids use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The patient is temporarily totally disabled. In this case, the treater indicates a decrease in pain with current medications which include Norco, stating "he was unable to get out of bed with taking any less Norco than 2 QID" per 7/3/14 report. But there is no discussion of this medication's efficacy in terms of functional improvement using numerical scale or validated instrument. Quality of life change, or increase in specific activities of daily living are not discussed. There is no discussion of return to work or change in work status attributed to the use of the opiate. Urine toxicology is not included in the provided reports, and no other aberrant behavior monitoring is provided such as CURES report. Finally, MTUS does not support more than 60mg/day for Hydrocodone per page 90. Given the lack of sufficient documentation regarding chronic opiates management as required by MTUS, a slow taper off the medication is recommended at this time. The request IS NOT medically necessary.

Purchase of manual wheelchair: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Page(s): 99. Decision based on Non-MTUS Citation Official disability guidelines, Knee chapter, Wheelchair.

Decision rationale: This patient presents with lower back pain, pain in the lower extremities, groin, hips, thighs, and heels. The treater has asked for PURCHASE OF MANUAL WHEELCHAIR on 10/9/14. The treater has requested a motorized wheelchair in 10/9/14 report, which the utilization review letter dated 1/8/15 has modified to a manual wheelchair. The patient ambulates with a straight cane, weighs in excess of 300 pounds, is severely deconditioned, and requires mod-max assist with all transfers and many ADL's per 7/21/14 report. The patient is in danger of falling and severely injuring himself as well as his caregivers. Due to his morbid obesity, severe back/leg/foot pain, he is unable to safely leave the house per 7/21/14 report. Regarding wheelchairs, ODG recommends if the patient requires and will use a wheelchair to

move around in their residence, and it is prescribed by a physician. The patient is temporarily totally disabled. In this case, the patient has a chronic pain condition, morbid obesity, and is unable to transfer and do ADLs without assistance. The treater has recommended a motorized wheelchair as he also has difficulty ambulating slow, shuffling, wide-based gait, facial appearance grimacing, solicits assistance frequently in physical exam dated 7/3/14. The requested manual wheelchair IS medically necessary.

Home health care evaluation: Overturned

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

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

Decision rationale: This patient presents with lower back pain, pain in the lower extremities, groin, hips, thighs, and heels. The treater has asked for HOME HEALTH CARE EVALUATION on 10/9/14. The patient weighs in excess of 300 pounds, is severely deconditioned, and requires mod-max assist with all transfers and many ADL's. He is in danger of falling and severely injuring himself as well as his caregivers per 7/3/14 report. Regarding home health services, MTUS recommends only for otherwise recommended medical treatment 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, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. The patient is temporarily totally disabled. In this case, the patient weighs over 300 pounds, has difficulty ambulating from his morbid obesity/chronic pain, and requires max assist for transfers and most ADLs. He is also in danger of falling and injuring himself and caregivers. The requested home care evaluation would appear reasonable. The request IS medically necessary.

Neurosurgery re-evaluation: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Independent medical examination and consultations. Ch: 7 page 127.

Decision rationale: This patient presents with lower back pain, pain in the lower extremities, groin, hips, thighs, and heels. The treater has asked for NEUROSURGERY RE-EVALUATION on 10/9/14. There is no documentation of any prior neurosurgery evaluation per review of reports. The QME has deemed this unfortunate gentleman requires immediate surgery to address his unresolved constant severe pain/weakness related to his industrial injury per 10/9/14 report. Regarding consultations, ACOEM states that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are

present, or when the plan or course of care may benefit from additional expertise. The patient is temporarily totally disabled. In this case, the patient has a chronic pain condition and a surgery is being planned. The treater has requested a consultation re-evaluation, which has the potential to move this case forward per ACOEM guidelines. The requested consultation IS medically necessary.