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| Case Number: | CM15-0031290 | | |
| Date Assigned: | 02/24/2015 | Date of Injury: | 04/07/2013 |
| Decision Date: | 04/07/2015 | UR Denial Date: | 02/05/2015 |
| Priority: | Standard | Application Received: | 02/19/2015 |

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: Georgia

Certification(s)/Specialty: Anesthesiology, Pain Management

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 60 year old male who sustained an industrial injury on 04/07/13. He reports left knee, neck, back, and right lower extremity pain. Diagnoses include post laminectomy syndrome thoracic region, chronic postoperative pain, and sciatica. Treatments to date include medications and surgery. In a progress note dated 01/24/15 the treating provider recommends back brace, lumbar MRI and CT of the cervical and thoracic spine, portable bedrail, acupuncture, reconsultation with spine surgeon, home assistance, and medications including Zanaflex, Lyrica, Effexor, and Naprosyn. On 02/06/15 Utilization Review non-certified the portable bedrail, citing ODG guidelines. The home assistance and tizanidine were noncertified, citing MTUS guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home assistance: 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 Home Health Page(s): 51.

Decision rationale: Home assistance Per CA MTUS page 51. Home health services are recommended 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. (CMS, 2004). The claimant does not have a medical condition that denotes he is homebound on part-time or full time basis.

Portable bedrail: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee; Home Assistance.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare guidelines 2013 Criteria for coverage of hospital beds. (Medicare.com).

Decision rationale: Portable bedrail is not medically necessary. The Ca MTUS and ODG does not present a specific statement. The evidence for my rationale is provided by the Medicare criteria for hospital beds. Per Medicare criteria to qualify for a hospital bed or it's accessories the patient must show a 1) change in position not possible on a normal bed; 2) Lay or sleep in positions not possible with a normal bed in order to relieve pain; 3) has to sleep with the head of the bed higher than 30 because of conditions such as congestive heart failure, breathing problems, or other types of problems; 4) use traction equipment that must be attached to a hospital bed; 5) Furnish certificate of medical necessity that is completed, signed and dated by the treating doctor. The medical records lack documentation of a medical necessity for a portable bedrail as listed by Medicare criteria or other similar guidelines.

Tizanidine 4mg QTY:60.00 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants: Tizanidine Page(s): 67.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Spasmodic Page(s): 65.

Decision rationale: Tizanidine 4mg #60 with 1 refill is not medically necessary. According to MTUS page 65, Tizanidine is a centrally acting alpha2- adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. MTUS further states that Tizanidine may be used as first line option to treat myofascial pain. The claimant was not diagnosed with myofascial pain and Tizanidine use for his current diagnosis would be off label. Tizanidine is therefore not medically necessary.

