MAXIMUS Federal Services

Case Number:	CM15-0069883		
Date Assigned:	04/28/2015	Date of Injury:	09/20/2005
Decision Date:	08/14/2015	UR Denial Date:	04/02/2015
Priority:	Standard	Application Received:	04/13/2015

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: New York
Certification(s)/Specialty: Internal 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 September 20, 2005. He has reported low back pain and neck pain and has been diagnosed with status post lumbar fusion L5-S1, possible lumbar discogenic pain, possible bilateral lumbar facet pain, possible lumbar sprain/strain, bilateral lumbosacral radicular pain, cervical discogenic pain at C3-4, and bicipital neuralgia. Treatment has included surgery, therapy, medications, acupuncture, and injections. Currently the injured worker had cervical tenderness with restricted range of motion. There was bilateral lumbar facet tenderness noted. The treatment request included medications, cervical pillow, tempurpedic orthopedic mattress, aquatic therapy, home health care, and transportation.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription for MS Contin 100mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter--Opioids.

Decision rationale: According to the CA MTUS and ODG,MS Contin is an opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's functional benefit. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

1 prescription for Topmax 25mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topiramate (Topamax) Anti-epilepsy drugs (AEDs) Page(s): 17-21.

Decision rationale: According to the CA MTUS (2009), Anti-Epilepsy Drugs (AEDs) are considered a first-line treatment for neuropathic pain. Topiramate (Topamax) has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of central etiology. It is still considered for use for neuropathic pain when other anticonvulsants fail. Review of Medical Records does not show that previous use of this medication has been effective in this injured worker for maintaining any functional improvement. Based on the currently available information, the medical necessity for this medication has not been established.

1 prescription for Norco 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter--Opioids.

Decision rationale: According to the CA MTUS and ODG, Norco 10/325mg (Hydrocodone/ Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation

of the medication's functional benefit. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

1 prescription for Fioricet #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter--Barbiturate-containing analgesic agents (BCAs).

Decision rationale: This prescription for Fioricet is evaluated in light of the Official Disability Guidelines (ODG) recommendations. Per ODG, is not recommended for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. Fioricet is commonly used for acute headache, with some data to support it, but there is risks of medication overuse as well as rebound headache. The AGS updated Beers criteria for inappropriate medication use includes barbiturates. (AGS, 2012) There is no documentation in the submitted Medical records of the injured worker that this medication is relieving her symptoms. Of note request does not specify strength, and frequency. The Requested Treatment Fioricet is not medically necessary and appropriate.

1 prescription for Ambien CR 12.5mg #20: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic).

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

Decision rationale: Ambien (Zolpidem) is a prescription non-benzodiazepine hypnotic, which is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Ambien can be habit-forming, and may impair function and memory more than opioid analgesics. There is also concern that Ambien may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology, and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. In this case, the injured worker has chronic pain, and the submitted documentation does not indicate that Ambien has helped this injured worker. The requested medication is not medically necessary.

1 cervical pillow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute and Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter--Pillow.

Decision rationale: Official Disability Guidelines (ODG) recommends use of a neck support pillow while sleeping, in conjunction with daily exercise. This RCT concluded that subjects with chronic neck pain should be treated by health professionals trained to teach both exercises and the appropriate use of a neck support pillow during sleep; either strategy alone did not give the desired clinical benefit. (Helewa, 2007) Cervical Pillow cannot be considered durable medical equipment, as it is useful to a person in the absence of illness or injury and it is not primarily and customarily used to serve a medical purpose. There is no mention of exercises this injured worker has been taught. The requested treatment 1 cervical pillow is not medically necessary and appropriate as it does not meet these guidelines.

1 Tempurpedic orthopedic mattress: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back & Lumbar & Thoracic (Acute and Chronic).

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 Chapter, Mattress Selection Knee and Leg Chapter, Durable medical equipment (DME).

Decision rationale: The request for Tempurpedic orthopedic mattress is evaluated in light of the Official Disability Guidelines (ODG) recommendations. ODG does not support any type of specific mattresses or bedding for chronic pain. Mattress selection is an individual decision and depends on personal preference. It is typically not part of medical treatment process. Tempurpedic orthopedic mattress cannot be considered durable medical equipment, as it is useful to a person in the absence of illness or injury and it is not primarily and customarily used to serve a medical purpose. The submitted Medical records of injured worker do not mention of any wounds or limitations for which the patient is not able to properly change his positions in his own mattress. The Requested Treatment for Tempurpedic orthopedic mattress, to address low back and neck pain, is not medically necessary.

8 aquatic therapy sessions: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter-Aquatic therapy.

Decision rationale: Official Disability Guidelines (ODG) recommends Aquatic therapy as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, especially deep water therapy with a floating belt as opposed to shallow water requiring weight bearing, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. Aquatic exercise appears to have some beneficial short-term effects for patients with hip and/or knee osteoarthritis while no long-term effects have been documented. Positive short-term effects include significantly less pain and improved physical function, strength, and quality of life. For people who have significant mobility or function limitations and are unable to exercise on land, aquatic exercise is a legitimate alternative that may enable people to successfully participate in exercise. In this case, the available records do not indicate that the injured worker has significant mobility or function limitations and is unable to participate in weight bearing physical activities. The Requested Treatment 8 aquatic therapy session is not medically necessary and appropriate.

1 home healthcare 4 hours/ day for 3 days a week (total 12 hours per week) for unknown number of weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic).

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

Decision rationale: CA MTUS guidelines state Home health services is recommend 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. The Medical records do not substantiate that the injured worker is homebound or has any skilled needs. 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. Review of the submitted medical records of the injured worker do not meet the guidelines as cited, therefore, the requested Treatment 1 home healthcare 4 hours/ day for 3 days a week (total 12 hours per week) for unknown number of weeks is not medically necessary.