MAXIMUS Federal Services

Case Number:	CM14-0119742		
Date Assigned:	08/06/2014	Date of Injury:	05/05/2000
Decision Date:	10/31/2014	UR Denial Date:	07/17/2014
Priority:	Standard	Application Received:	07/28/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and Pain Management, has a subspecialty in Interventional Spine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 44 years old male with an injury date on May 05, 2000. Based on the 07/08/2014 progress report the patient has history of work-related injury with significant chronic pain and muscle spasms. According to this report, the patient complains of pain all over. The patient described the pain as annoying, intense and severe; with more pain. Physical exam findings were not included in the report for review. Patient is using a manual wheelchair. The Juan 19, 2014 report indicates the patient has had difficulty with activities of daily living. That medication partially helps, and that pain is rated as a 9/10. The April 24, 2014 report indicates pain over the lumbar intervertebral space and left sacroiliac joint. There were no other significant findings noted on this report. The utilization review denied the request on July 17, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone (10mg, #180): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids, On-going Management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Opiate Medications for chronic pain, Criteria for use of opioids Page(s): 60, 61, 78, 88.

Decision rationale: For chronic opiate use, California MTUS Guidelines states that pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument. Guidelines 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. Oxycodone was first mentioned in the February 27, 2014 report; it is unknown exactly when the patient initially started taking this medication. The reports show numerical scale to assessing the patient's pain levels but no assessment of the patient's average pain, with and without medication. There are no discussions regarding functional improvement specific to the opiate use. None of the reports discusses significant change in activities of daily living (ADLs), change in work status, or return to work attributed to use of Oxycodone. There is no opiate monitoring such as urine toxicology. The California MTUS Guidelines requires not only anagesia but also documentation of ADLs and functional changes. Given the lack of sufficient documentation demonstrating efficacy from chronic opiate use, the request is not medically necessary.

Baclofen (10mg, #180 with 1 refill): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63, 64.

Decision rationale: The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short-term treatment of acute exacerbation in patients with chronic low back pain (LBP). Muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility; however, in most LBP cases, they showed no benefit beyond NSAIDs and pain and overall improvement. A short course of muscle relaxant may be warranted for patient's reduction of pain and muscle spasms. However, Baclofen was first mentioned in the February 27, 2014 report; and it is unknown exactly when the patient initially started taking this medication. The treating physician is requesting #180; Baclofen is not recommended for long-term use. The treating physician does not mention that this is for a short-term use. Therefore, the request is not medically necessary.

Klonopin (1mg, #60 with 1 refill): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The California MTUS Guidelines do not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Only short-term use of this medication is recommended for this medication.

Review of reports show the patient has been prescribed Klonopin since February 27, 2014 and it is unknown exactly when the patient initially started taking this medication. It would appear that this medication is prescribed on a long-term basis, longer than a month. The California MTUS Guidelines does not support long-term use of this medication and therefore, the request is not medically necessary.

Soma (350mg, #120 with 1 refill): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63, 64.

Decision rationale: The California MTUS Guidelines recommended non-sedating muscle relaxants with caution as a second line option for short-term treatment of acute exacerbation in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility; however, in most LBP cases, they showed no benefit beyond NSAIDs and pain and overall improvement. A short course of muscle relaxant may be warranted for patient's reduction of pain and muscle spasms. However, the treating physician is requesting Soma; the patient has been on Soma since February 27, 2014. Soma is not recommended for long-term use. The treating physician does not mention that this is for a short-term use. Therefore, the request is not medically necessary.

Ketorolac (10mg, #12 with 1 refill): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects Page(s): 70.

Decision rationale: The California MTUS Guidelines reveal the following regarding NSAID's, specific drug list & adverse effects; Ketorolac (Toradol, generic available) is not indicated for minor or chronic painful conditions. Review of reports show the patient has been prescribed Ketorolac since February 27, 2014 and it is unknown exactly when the patient initially started taking this medication. In this case, the patient presents with chronic pain all over. This medication is not recommended for chronic painful conditions. Therefore, the request is not medically necessary.

Lidoderm Patches (5%, #60 with 5 refills): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The California MTUS Guidelines state that Lidoderm patches may be recommended for neuropathic pain that is peripheral and localized when trials of antidepressants and anti-convulsants have failed. Review of the reports show the patient has pain all over but this is not a localized condition. Furthermore, the treating physician does not discuss how this patch is used and with what effect. The California MTUS Guidelines require documentation of pain and function when medications are used for chronic pain. Therefore, the request is not medically necessary.

Handicap Vehicle with Controls: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg Chapter, Wheelchair

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter Power mobility devices

Decision rationale: The California MTUS Guidelines states that power mobility devices are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair. Review of reports show no functional mobility deficit and the patient is using a manual wheelchair to move about. Guidelines further state that if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. Therefore, the request is not medically necessary.

Tire Changing Kit (for manual wheelchair): Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, durable medical equipment.

Decision rationale: In the Official Disability Guidelines, durable medical equipment is defined as an equipment that is primarily and customarily used to serve a medical purpose and generally not useful to a person in the absence of illness or injury. Review of reports show that the patient isusing a manual wheelchair. In this case, the requested tire changing kit for manual wheelchair appears necessarily serves a specific medical purpose. Therefore, the request is medically necessary.ly serves a specific medical purpose. Recommendation is for authorization.

Inner Tubes (for manual & spares: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, durable medical equipment.

Decision rationale: In the Official Disability Guidelines, durable medical equipment is defined as an equipment that is primarily and customarily used to serve a medical purpose and generally not useful to a person in the absence of illness or injury. Review of reports show that the patient is using a manual wheelchair. In this case, the requested inner tubes for manual & spares appears necessarily serve a specific medical purpose. Therefore, the request is medically necessary.

Bilateral Wrist Braces: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264.

Decision rationale: Regarding the wrist brace, ACOEM Practice Guidelines states that the initial treatment of carpal tunnel syndrome should include night splints. Day splints can be considered for patient comfort as needed to reduce pain, along with work modifications. In this case, there were no mentions of the patient is suffering from CTS to recommend a wrist brace. Therefore, the request is not medically necessary.

Interferential (IF) Unit (#4): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Interferential Current Stimulation (.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

Decision rationale: The California MTUS Guidelines states that interferential current stimulation is not recommended as an isolated intervention. Guidelines also recommend trying the unit for one-month before a home unit is provided, if indicated. Indications are pain ineffectively controlled with medication; history of substance abuse; post-operative use; unresponsive to conservative measures. In this case, the patient does not present with a specific indication for IF unit and has not trialed the unit for a month to determine effectiveness. Therefore, the request is not medically necessary.

OrthoStim Unit (#4): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation Page(s): 121.

Decision rationale: An OrthoStim 4 Unit is a high volt pulsed current stimulation and neuromuscular electrical stimulation. The California MTUS Guidelines does not support neuromuscular stimulator (NMES) except for stroke rehabilitation. This patient presents with pain all over for which this unit is not indicated. Therefore, the request is not medically necessary.

Electric Wheelchair Replacement: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Power mobility devices.

Decision rationale: The California MTUS Guidelines state that power mobility devices are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair. Review of reports show no functional mobility deficit and the patient is using a manual wheelchair to move about. Guidelines further state that if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. The requested electric wheelchair replacement does not appear medical necessary at this time as the patient has mobility with a wheelchair. In addition, there are no specific diagnosis with neurologic deficits that show weakness or loss of muscle function requiring an electric wheelchair. The patient presents with pain only. Examination findings do not document loss of limb function. Therefore, the request is not medically necessary.