MAXIMUS Federal Services

Case Number:	CM14-0138628		
Date Assigned:	09/05/2014	Date of Injury:	03/11/2005
Decision Date:	10/10/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	08/27/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 injured worker is a 45 year old male who had a work related injury on 03/11/05. There were no clinical notes from the requesting provider. The only other clinical documentation submitted for review besides the latest utilization review was a vocational evaluation. All clinical information was obtained from the utilization review on from 08/08/14. Progress report dated 07/23/14 noted low back pain radiating to lower extremities, status post L5-S1 lumbar fusion on 01/13/10, depression and frustration due to chronic pain, left hip pain, compensable consequence due to chronic gait dysfunction from low back pain, GERD symptomatology due to pain medication, insomnia due to chronic pain, and difficulty with erection and sexual functioning. The injured worker had a fall on 06/22/11 due to his leg giving out, and the four wheeled walker not working well. He still noted some lumpiness of the left temporal area. Objective findings included lumbar range of motion 70% of normal, left straight leg raise positive at 70 degrees and right at 80 degrees. Positive Lasegue test on the left. Hip tenderness, Patrick sign on the left. Mood and affect slightly depressed. He was diagnosed with status post L5-S1 lumbar fusion 01/13/10, left lumbar radiculopathy, failed back syndrome, coccygeal strain, spasticity, and hyperreflexia upper extremities and lower extremities non-industrial, depression, frustration, left hip pain, GERD, insomnia difficulty with erection and sexual functioning, fall on 06/22/11. The patient had spinal cord stimulator trial of 12/20/11 and status post intrathecal opioid trial of 08/10/12. Prior utilization review on 08/08/14 was non-certified. Current request was for Queen Sized [redacted] Motorized Bed or [redacted] Motorized Bed. Four Wheeled Walker. Diclofenac sodium 100mg #60, Omeprazole 20mg #60. Milk of Magnesia, Lab Work with Liver Function Test, and Renal Function Test.

IMR ISSUES, DECISIONS AND RATIONALES

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

Queen size [redacted] motorized bed or [redacted] motorized bed: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Online version, Durable Medical Equipment.

Decision rationale: The request for queen size [redacted] motorized bed or [redacted] motorized bed is not medically necessary. The clinical documentation submitted for review does not support the request. There is no clinical reason documented why this bed has been requested. Therefore, medical necessity has not been established.

Four wheeled walker: 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 & Leg

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg chapter, walking aids (canes, crutches, braces, orthoses, & walkers)

Decision rationale: The request for the four wheeled walker is medically necessary. The patient has fallen, secondary to his leg giving out on him. He cannot stand and walk greater than 10-20 minutes without holding on to an assistive device. Therefore medical necessity has been established.

Diclofenac Sodium (Voltaren EC) 100mg #60: Upheld

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

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

Decision rationale: As noted on page 70 of the Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended as a second-line treatment after acetaminophen for acute exacerbations of chronic pain. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute lower back pain. Additionally, it is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. As such, the request for this medication cannot be established as medically necessary.

Omeprazole 20mg #60: 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 - online version Integrated treatment/Disability Duration Guidelines Pain (Chronic) Proton pump inhibitors (PPIs)

Decision rationale: The request for Omeprazole 20mg #60 is predicated on the request for Diclofenac, as that has not been found to be medically necessary, as such the subsequent request is not necessary.

Milk of Magnesia: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Ternent CA, Bastawrous AL, Morin NA, Ellis CN, Hyman NH, Bule WD, Standards Practice Task Force of The American Society of Colon and Rectal Surgeons. Practice parameters for the evaluation and management of constipation. Dis Colon Rectum 2007 Dec;50(12):2013-22

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: http://www.webmd.com/drugs/2/drug-326/milk-of-magnesia-oral/details

Decision rationale: This medication is used for a short time to treat occasional constipation. The clinical documentation submitted for review does not support the request. There is no clinical indication that the injured worker suffers from constipation.

Lab work with Liver Function Test (LFT) and Renal Function Test (RFT): Overturned

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

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

Decision rationale: As noted on page 70 of the Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended as a second-line treatment after acetaminophen for acute exacerbations of chronic pain. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute lower back pain. Package inserts for NSAIDs recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests. The injured worker has been on NSAID's for a prolonged period of time, therefore medical necessity has been established.