

Case Number:	CM15-0001606		
Date Assigned:	01/12/2015	Date of Injury:	08/22/2007
Decision Date:	03/10/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	01/05/2015

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 patient is a year old female with a work injury dated 8/22/07. Her diagnoses include sprain of the neck; brachial neuritis or radiculitis; degeneration of the cervical intervertebral disc; sprain of the shoulder and upper arm; wrist sprain; carpal tunnel syndrome; sprain of lumbar; thoracic/lumbosacral neuritis or radiculitis; chondromalacia patella; displacement of cervical intervertebral disc without myelopathy. Under consideration are requests for Tylenol #3 300/30mg quantity 60 and Purchase of cushion quantity 1. The patient is status post right ring finger release on 5/19/08. The patient is status post right knee surgery. Per documentation there is an 11/17/14 progress note that states that the patient has low back pain with numbness and tingling to the right lower extremity that increases with sitting. Her current medications include Tylenol #3. The patient is 6-7/10 with meds and 8/10 without medis. The duration of relief was 3 hours. The patient could perform ADLS, improved participation in a home exercise program with meds. The physical exam reveals WHSS on right ring finger. Positive bilateral Tinel and Phalen. Decreased sensation along distal medial bilaterally. The treatment plan included bracing, home exercise, refill of Tylenol #3; cushion for prolonged sitting to decrease lumbar spine pain. The patient was temporarily totally disabled. There were multiple handwritten only partially legible prior progress notes submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tylenol #3 300/30mg quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): (s) 78-80, 92, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78-80.

Decision rationale: Tylenol #3 300/30mg quantity 60 is not medically necessary per the MTUS. The MTUS Chronic Pain Medical Treatment Guidelines state that a pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. The documentation submitted reveals that the patient has been on long term opioids without significant functional improvement. The patient continues to be temporarily totally disabled which implies a total state of treatment failure. Therefore the request for Tylenol #3 is not medically necessary.

Purchase of cushion; quantity 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar Supports

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee and Leg

Decision rationale: Purchase of cushion, quantity 1 is not medically necessary per the ODG. The MTUS does not address cushion. The ODG addresses durable medical equipment. The ODG states that the term DME is defined as equipment which: (1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients; (2) Is primarily and customarily used to serve a medical purpose; (3) Generally is not useful to a person in the absence of illness or injury; & (4) Is appropriate for use in a patient's home. The request for a cushion is not medically necessary as this is an item which is not meant to withstand repeated use (i.e. rented by successive patients.) It is something that can be considered useful to a person in the absence of illness or injury. The ODG and the MTUS do not address cushion as an item that is medically necessary and supported for an evidence based effective treatment for low back pain. The request for purchase of cushion is not medically necessary.