

<b>Case Number:</b>	CM15-0119773		
<b>Date Assigned:</b>	06/30/2015	<b>Date of Injury:</b>	07/24/2000
<b>Decision Date:</b>	09/22/2015	<b>UR Denial Date:</b>	06/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/22/2015

### 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: Texas, Illinois

Certification(s)/Specialty: Preventive Medicine, Occupational 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 53 year old male, who sustained an industrial injury on 7/24/2000. He reported he was on a stand-up forklift which flipped and injured the lower back. Diagnoses include lumbar degenerative discogenic disease, status post multiple lumbar spine surgeries, status post revision lumbar fusion, chronic intractable low back pain, and severe spinal stenosis. Treatments to date include activity modification, medication therapy, physical therapy, acupuncture treatments, therapeutic joint injections, epidural injections, and implantation of a spinal cord stimulator. Currently, he complained of an increase in the chronic low back pain with radiation to bilateral lower extremities. On 5/5/15, the physical examination documented pain and tenderness with palpation of the lumbar region. There was positive straight leg raise bilaterally. There was decreased strength and decreased sensation to bilateral lower extremities. The plan of care included Norco 10/325mg, two tablets four times daily, #250; Ambien 10mg, #30; Nucynta 100mg two tablets three times daily #180; a motorized wheelchair, captain four wheeler, with carrier; and home assistance two times a week for three months.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Wheelchair motorized:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Knee Chapter, Power Mobility Devices (PMDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Page(s): 99.

**Decision rationale:** The injured worker sustained a work related injury on 7/24/2000. The medical records provided indicate the diagnosis of lumbar degenerative discogenic disease, status post multiple lumbar spine surgeries, status post revision lumbar fusion, chronic intractable low back pain, and severe spinal stenosis. Treatments to date include activity modification, medication therapy, physical therapy, acupuncture treatments, therapeutic joint injections, epidural injections, and implantation of a spinal cord stimulator. The medical records provided for review do indicate a medical necessity for Wheelchair motorized. The MTUS does not recommend Power mobility devices (PMDs) 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, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. The medical records indicate the injured worker has had multiple surgeries for lumbar radiculopathy. The worker has weakness of the lower extremities associated with sensory deficit; and the lower limbs has on an occasion given out on him. The worker suffers from right shoulder impingement that limits motion. The requested treatment is medically necessary due to problems with bilateral lower limbs and right lower limb.

**Home assistance 2/wk x3 months:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines home health services Page(s): 51.

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

**Decision rationale:** The injured worker sustained a work related injury on 7/24/2000. The medical records provided indicate the diagnosis of lumbar degenerative discogenic disease, status post multiple lumbar spine surgeries, status post revision lumbar fusion, chronic intractable low back pain, and severe spinal stenosis. Treatments to date include activity modification, medication therapy, physical therapy, acupuncture treatments, therapeutic joint injections, epidural injections, and implantation of a spinal cord stimulator. The medical records provided for review do not indicate a medical necessity for Home assistance 2/wk x3 months. The MTUS states that Home health services is only recommended 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. The medical records do not indicate the injured worker is homebound; besides the request does not specify why the home health assistance is needed.

**Norco 10/325mg #240:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 82.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-88.

**Decision rationale:** The injured worker sustained a work related injury on 7/24/2000. The medical records provided indicate the diagnosis of lumbar degenerative discogenic disease, status post multiple lumbar spine surgeries, status post revision lumbar fusion, chronic intractable low back pain, and severe spinal stenosis. Treatments to date include activity modification, medication therapy, physical therapy, acupuncture treatments, therapeutic joint injections, epidural injections, and implantation of a spinal cord stimulator. The medical records provided for review do not indicate a medical necessity for Norco 10/325mg #240. The MTUS recommends the use of the lowest dose of opioids for the short term treatment of moderate to severe pain. The MTUS recommends the daily use of opioids not to exceed 120 morphine equivalents. Also, the MTUS recommends that individuals on opioid maintenance treatment be monitored for analgesia (pain control), activities of daily living, adverse effects and aberrant behavior; the MTUS recommends discontinuation of opioid treatment if there is no documented evidence of overall improvement or if there is evidence of illegal activity or drug abuse or adverse effect with the opioid medication. The injured worker is not properly monitored for pain control, adverse effects, and activities of daily living. The medical records indicate the injured worker has been taking 300 morphine equivalents of opioids without overall improvement.

**Nucynta 100mg #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 79.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Tapentadol (Nucynta).

**Decision rationale:** The injured worker sustained a work related injury on 7/24/2000. The medical records provided indicate the diagnosis of lumbar degenerative discogenic disease, status post multiple lumbar spine surgeries, status post revision lumbar fusion, chronic intractable low back pain, and severe spinal stenosis. Treatments to date include activity modification, medication therapy, physical therapy, acupuncture treatments, therapeutic joint injections, epidural injections, and implantation of a spinal cord stimulator. The medical records provided for review do not indicate a medical necessity for Nucynta 100mg #180. The MTUS recommends the use of the lowest dose of opioids for the short term treatment of moderate to severe pain. The MTUS recommends the daily use of opioids not to exceed 120 morphine equivalents. Also, the MTUS recommends that individuals on opioid maintenance treatment be monitored for analgesia (pain control), activities of daily living, adverse effects

and aberrant behavior; the MTUS recommends discontinuation of opioid treatment if there is no documented evidence of overall improvement or if there is evidence of illegal activity or drug abuse or adverse effect with the opioid medication. The injured worker is not properly monitored for pain control, adverse effects, and activities of daily living. The Official Disability Guidelines states that Tapentadol (Nucynta) is only recommended as second line therapy for patients who develop intolerable adverse effects with first line opioids. The medical records indicate the injured worker has been taking 300 morphine equivalents of opioids without overall improvement.

**Ambien 10mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Mental Illness & Stress Chapter, Zolpidem (Ambien).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Zolpidem (Ambien).

**Decision rationale:** The injured worker sustained a work related injury on 7/24/2000. The medical records provided indicate the diagnosis of lumbar degenerative discogenic disease, status post multiple lumbar spine surgeries, status post revision lumbar fusion, chronic intractable low back pain, and severe spinal stenosis. Treatments to date include activity modification, medication therapy, physical therapy, acupuncture treatments, therapeutic joint injections, epidural injections, and implantation of a spinal cord stimulator. The medical records provided for review do not indicate a medical necessity for Ambien 10mg #30. The MTUS is silent on Ambien, but the Official Disability Guidelines states that Zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is recommended for short-term (7-10 days) treatment of insomnia. The requested treatment is not medically necessary because, the records indicate the injured worker has been taking this medication for some time; besides, the requested quantity exceeds that recommended by the guidelines.