

Case Number:	CM15-0167605		
Date Assigned:	09/08/2015	Date of Injury:	05/04/2004
Decision Date:	11/12/2015	UR Denial Date:	07/30/2015
Priority:	Standard	Application Received:	08/25/2015

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: Pediatrics, 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:

This is a 52 year old male with a May 4, 2004 date of injury. A progress note dated July 1, 2015 documents subjective complaints (left foot pain with numbness; lower back pain; right hip pain; depression and insomnia; pain rated at a level of 5 to 6 out of 10 with medications and 9 to 10 out of 10 without meds), objective findings (mild tenderness to palpation and spasm of the paralumbar muscles; decreased range of motion of the lumbar spine; slightly to moderate antalgic gait; using a cane for walking; tenderness to palpation over the bottom and top of the left foot and plantar fascia; calluses over the second and fifth metatarsal of the left foot and point tenderness over the left great toe over the sole aspect; decreased range of motion of the left foot; valgus deformity of the left big toe as compared to the right side; tenderness of the lateral right hip; positive Patrick's test on the right; range of motion of the right hip limited due to pain), and current diagnoses (status post contusion of the left foot with associated tibial sesamoid fracture with chronic pain in the big toe and left foot; lumbar strain due to gait dysfunction; right hip strain due to gait dysfunction; secondary depression due to chronic pain). Treatments to date have included left foot surgery on October 30, 2008, and medications. The medical record indicates that the injured worker had difficulty getting in and out of bed due to balance issues, and had difficulty with activities of daily living and housework. The treating physician documented a plan of care that included a medical bed, Diclofenac gel 1% 2-4 grams for the left foot, Percocet 7.5-325mg #100, and assistance with home housework four to six hours per week.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medical 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, Knee & Leg Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Coverage Determination (NCD) for HOSPITAL BEDs (280.7).

Decision rationale: MTUS and ODG are silent on the criteria for a hospital bed. Medicare NCD guidelines were referenced for the necessity of a hospital bed. A physician's prescription and such additional documentation as the Medicare Administrative Contractor (MAC) medical staff may consider necessary, including medical records and physicians' reports, must establish the medical necessity for a hospital bed due to one of the following reasons. The patient's condition requires positioning of the body; e.g., to alleviate pain, promote good body alignment, prevent contractures, avoid respiratory infections, in ways not feasible in an ordinary bed; or the patient's condition requires special attachments that cannot be fixed and used on an ordinary bed. The records accompanying the request note that the hospital bed would be utilized for easier transfer in and out of bed and there are no indications that the bed was required for repositioning of special attachments. The request is not medically necessary and appropriate.

Diclofenac gel 1% 2-4 grams to be applied to left foot: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain - Voltaren® Gel (diclofenac).

Decision rationale: Per MTUS guidelines topical NSAID's are indicated for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. Topical NSAID's are recommended for short-term use (4-12 weeks). FDA-approved agents: Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The most common adverse reactions were dermatitis and pruritus. Per ODG guidelines, Voltaren gel is not recommended as a first-line treatment. See Diclofenac Sodium (Voltaren), where Voltaren Gel is recommended for osteoarthritis after failure of an oral NSAID, or contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with diclofenac, including topical formulations. According to FDA MedWatch, postmarketing surveillance of Voltaren Gel has reported cases of severe hepatic reactions, including liver necrosis, jaundice,

fulminant hepatitis with and without jaundice, and liver failure. The records note that the IW was also taking oral NSAID's indicating that the IW tolerated them without significant side effects and there was no notation of failure of oral NSAID's to treat the pain. The request is not medically necessary and appropriate.

Percocet 7.5/325mg 1 tablet tid prn #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: Per MTUS guidelines documentation should include review and documentation of pain relief, functional status, appropriate medication use, and side effects. The IW has been on long term opioids which is not recommended. 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. Without documentation of response to the opioid this request is not medically necessary and reasonable at this time.

Assistance with home housework 4-6 hours per week: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

Decision rationale: Per MTUS and ODG guidelines, home health services are recommended 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. 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. There was no indication in the medical record that the IW required medical care nor that he was considered homebound. This request is not medically necessary and appropriate.