

Case Number:	CM14-0149084		
Date Assigned:	09/18/2014	Date of Injury:	07/27/2011
Decision Date:	10/23/2014	UR Denial Date:	09/05/2014
Priority:	Standard	Application Received:	09/15/2014

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 Emergency 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 50-year-old male who reported an injury on 07/27/2011. The injured worker works at the [REDACTED] as an armed officer, where he was bit by a subject in the right biceps area, left elbow, and right thumb. The injured worker's treatment history included cystoscopy surgeries, medications, MRI studies, CT scans, and physical therapy. The injured worker was evaluated on 06/23/2014 and it was documented the injured worker complained of chronic low back pain. The injured worker states that driving caused 9/10 back pain on a scale of 10/10 and that injured worker was with all his medications that he took in the morning. He states that if he is not in a car sitting down, the medications bring his pain level down to about 7/10. Objective findings: no change. Medications included MS-Contin 30 mg, Oxycodone 5 mg, Zofran 800 mg, mirtazapine 15 mg, atorvastatin 10 mg, and trazodone 100 mg. The diagnoses included chronic prostatitis bilateral groin pain, history of bilateral inguinal hernia repair, post-traumatic stress disorder, depression, conversion disorder psychiatry, and S/P transurethral prostatectomy. The injured worker was evaluated on 08/13/2014 and it was documented the injured worker complained of abdominal and prostate pain. Level was 10/10. He was unable to sit or stand for a very long time. The injured worker had to lie in the side posture position due to the pain. Objective findings: the injured worker was walking with assistance on a front wheeled walker. He had difficulty standing up strain. He appeared in moderate distress. The request for authorization dated 08/25/2014 was for home health care and MS-Contin 30 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of MS Contin 30mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

Decision rationale: The requested is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) guidelines state that criteria for use for ongoing- management of opioids include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There was lack of evidence of opioid medication management and average pain, intensity of pain, or longevity, of pain relief. The provider failed to indicate urine drug screen for opioid compliance. The request lacked frequency and duration of medication. Given the above, the request for 1 prescription of MS-Contin 30 mg #180 is not medically necessary.

1 home health care for 5 hours a day, 7 days per week (maximum of 35 hours per week) for 3 months: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

Decision rationale: My rationale for why the requested treatment/service is or is not medically necessary: The requested is not medically necessary. The Chronic Pain Medical Treatment Guidelines (MTUS) only recommends Home Health Services for medical treatment for patients who are Home bound, 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 documents provided on 08/13/2014 lacked documentation of the injured worker being homebound, on a part time or "intermittent" basis. In addition, there was no indication the injured worker was post-op from surgery. The request for 1 home health care for 5 hours a day, 7 days per week (maximum of 35 hours per week) for 3 months is not medically necessary.