

Case Number:	CM13-0042838		
Date Assigned:	12/27/2013	Date of Injury:	02/01/2005
Decision Date:	04/30/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	10/18/2013

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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 patient is a 59-year-old female who reported an injury on 02/01/2005 due to a trip and fall. The patient's treatment history included injection therapy, physical therapy, surgical intervention, and a home exercise program. The patient was evaluated in December 2013. It was documented the patient had multiple body part complaints to include the bilateral knees, right upper extremity, right shoulder, and low back pain. It was noted the patient had 10/10 pain without medications that was reduced to 3/10 pain with medications. Physical findings included compartmental osteoarthritic changes of the left knee. The patient's diagnoses included lumbar radiculopathy, narcotic dependence, right knee internal derangement status post total knee arthroplasty, right knee pain, right rotator cuff tear, right torso and flank musculoskeletal pain, chronic pain syndrome, chronic pain-related insomnia, myofascial syndrome, neuropathic pain, and chronic pain-related depressive anxiety. The patient's treatment plan included continuation of medications to include Norco, Pamelor, Prilosec, Lactulose, Lidoderm, and Zanaflex. Consultation for a Functional Restoration Program was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

NESP-R PROGRAM CONSULTATION: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 30.

Decision rationale: The requested NESP-R program consultation is not medically necessary or appropriate. The California MTUS guidelines recommend a thorough evaluation for multidisciplinary programs for patients who are at risk for delayed recovery that have exhausted lesser forms of chronic pain management. The clinical documentation submitted for review does indicate the patient has undergone many forms of conservative treatment that have failed to provide consistent relief to the patient. The patient does have chronic pain rated at 3/10 with medications. However, the guidelines recommend Functional Restoration Programs for patients who are motivated to improve and return to work. The clinical documentation submitted for review does not provide any evidence that the patient is motivated to return to work and contribute to a successful outcome of the Functional Restoration Program. Therefore, the requested NESP-R program consultation is not medically necessary or appropriate.

SLEEP NUMBER 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 - Lumbar and Thoracic (Acute and Chronic).

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, Durable Medical Equipment (DME).

Decision rationale: The requested Sleep Number bed is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address the use of durable medical equipment. The Official Disability Guidelines outline durable medical equipment as appropriate when it is able to be rented, is not helpful to the patient in the absence of injury or illness, meets a functional deficit, and can assist the patient in the home. The clinical documentation submitted for review does not provide any evidence that this requested equipment would be appropriate for this patient in the absence of injury or illness. Additionally, a mattress is generally purchased. Therefore, it would not fall within the criteria of a rental for durable medical equipment. As such, the requested Sleep Number bed is not medically necessary or appropriate.

A WALKER WITH A SEAT: 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 and Leg (Acute and Chronic).

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.

Decision rationale: The request for a walker with a seat is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address walking aids. The Official Disability Guidelines recommend ambulation assistance for patients who have deficits that would benefit from assistive devices and provide safety for the patient. The clinical documentation submitted for review does not provide an adequate assessment of the patient's ability to ambulate. There is no documentation of functional deficits that would require the assistance of a walker with a seat. As such, the requested walker with a seat is not medically necessary or appropriate at this time.

NORCO 10/325MG #240: Upheld

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

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

Decision rationale: The request for Norco 10/325 mg is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends that the ongoing use of opioids in the management of chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, evidence that the patient is monitored for aberrant behavior, and managed side effects. The clinical documentation submitted for review does indicate that the patient has 10/10 pain that is reduced to 3/10 pain with medication usage. However, the clinical documentation does not specifically identify any functional benefit as result of medication usage. The clinical documentation indicates this patient has been on this medication for over a year. It is also noted that the patient is monitored for aberrant behavior with urine drug screens. However, without documentation of functional benefit, continued use is not supported. As such, requested Norco is not medically necessary or appropriate.

LIDODERM PATCHES 5% #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60,111.

Decision rationale: The request for Lidoderm patches 5% is not medically necessary or appropriate. The clinical documentation submitted for review does indicate the patient has been on this medication for an extended duration of time. The California Medical Treatment Utilization Schedule recommends medications that are used in the management of chronic pain be supported by documentation of functional benefit and evidence of pain relief. The clinical documentation submitted for review does provide evidence that the patient has pain relief with medications. It is noted the patient has 8/10 to 10/10 pain without medications that is reduced to 2/10 to 4/10 with medications. However, the clinical documentation submitted for review fails to

provide any evidence of functional benefit related to medication usage. As such, the requested Lidoderm 5% is not medically necessary or appropriate.