

<b>Case Number:</b>	CM13-0072670		
<b>Date Assigned:</b>	01/10/2014	<b>Date of Injury:</b>	10/25/2007
<b>Decision Date:</b>	06/19/2014	<b>UR Denial Date:</b>	12/17/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/31/2013

### 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 & Rehabilitation and is licensed to practice in California. 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 49-year-old male who reported an injury on 10/25/2007 after a fall off a ladder. The injured worker's treatment included psychiatric support, multiple medications, and surgical interventions. The injured worker was evaluated on 11/21/2013. It was documented that the injured worker had 6/10 pain with medications increased to a 9/10 without medications. It was documented that the injured worker's medications included Nortriptyline, Voltaren XR, methadone, and pantoprazole. Physical findings included restricted range of motion secondary to pain and lumbar facet pain that was considered unchanged from the last visit. The injured worker's diagnoses included post laminectomy syndrome of the lumbar region, radiculopathy, disorders of the meninges, lumbar discogenic pain, and lumbar facetogenic pain/facet arthropathy. The injured worker's treatment plan included continuation of medications and a home exercise program. It was noted that the injured worker underwent a point of care urine drug screen that was consistent with the injured worker's medication schedule.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 ADJUSTABLE HOSPITAL 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 (ODG), Low Back Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Mattress Selection.

**Decision rationale:** The requested adjustable hospital bed is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines do not recommend mattress selection as a medical prescription. Official Disability Guidelines state that mattress selection is subjective and depends on personal preference and individual factors. The clinical documentation submitted for review does not provide any justification for the need of a hospital bed. As such, the requested 1 adjustable hospital bed is not medically necessary or appropriate.

### **1 PRESCRIPTION OF VOLTAREN XR 100MG, #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Diclofenac (Voltaren)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Medications for Chronic Pain and NSAIDs (Non-Steroida.

**Decision rationale:** The requested Voltaren XR 100 mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of nonsteroidal anti-inflammatory in the management of chronic pain. However, California Medical Treatment Utilization Schedule recommends that continued use of medications be supported by documentation of functional benefit and evidence of pain relief. The clinical documentation submitted for review does indicate that the injured worker has been taking this medication since at least 09/2012. The clinical documentation does indicate that the injured worker has a reduction in pain. However, there is no documentation of functional benefit related to medication usage. Therefore, continued use of this medication would not be supported. As such, the requested prescription of voltaren XR 100 mg #60 is not medically necessary or appropriate. Additionally, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined.

### **1 PRESCRIPTION OF METHADONE HCL 10MG, #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Methadone..

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

**Decision rationale:** The requested 1 prescription of methadone HCl 10 mg #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for abhorrent behavior. The clinical documentation

submitted for review does provide evidence that the injured worker is monitored for abhorrent behavior and has significant pain relief related to medication usage. However, there is not documentation of functional benefit to support the continued use of this medication. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 09/2012. Therefore, continued use would not be supported. As such, the requested 1 prescription for methadone HCl 10 mg #90 is not medically necessary or appropriate. Additionally, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined.