

<b>Case Number:</b>	CM14-0107423		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	05/27/1994
<b>Decision Date:</b>	10/22/2014	<b>UR Denial Date:</b>	06/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain 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 58 year-old male who was reportedly injured on 5/27/1994. The most recent progress note dated 6/26/2014, indicates that there were ongoing complaints of left shoulder pain status post-surgery. The physical examination demonstrated left shoulder: for passive range of motion and for active forward elevation. No evidence that the rotator cuff is injured. No recent diagnostic studies were available for review. Previous treatment includes multiple surgeries, medications, physical therapy, and conservative treatment. A request was made for Tempur-Pedic mattress, oxycodone 15mg #20, and was not certified in the pre-authorization process on 6/20/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tempur-Pedic Mattress:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation [http://www.odgtwc.com/odgtwc/low\\_back.htm](http://www.odgtwc.com/odgtwc/low_back.htm)

**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 - Lumbar & Thoracic (Acute & Chronic) Mattress Selection. (Updated 8/22/2014).

**Decision rationale:** ODG guidelines state that there are no high-quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. Mattress selection is subjective and depends on personal preference and individual factors. After review of the medical records provided as well as the guidelines stated above, this request is deemed not medically necessary.

**Retrospective request for refill Oxycodone 15 mg 1 Q6 hrs prn 20 Refill 0 (DOS 6/10/2014):**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 74, 78, 93.

**Decision rationale:** MTUS treatment guidelines support short-acting opiates for the short-term management of moderate to severe breakthrough pain. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic pain; however, there is no clinical documentation of improvement in their pain or function with the current regimen. As such, this request is not considered medically necessary.