

<b>Case Number:</b>	CM15-0202095		
<b>Date Assigned:</b>	10/19/2015	<b>Date of Injury:</b>	03/13/2015
<b>Decision Date:</b>	11/25/2015	<b>UR Denial Date:</b>	10/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2015

### 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: North Carolina

Certification(s)/Specialty: Family Practice

### 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 56 year old male with a date of injury on 03-13-2015. The injured worker is undergoing treatment for status post fall injury with multiple fractures, T12 compression with Magnetic Resonance Imaging done on 03-06-2015 showing edema and retropulsion into the canal without cord impingement, left wrist fracture status post-surgery, persistent neck pain and headaches. He has a comorbid diagnosis of Hepatitis C. A physician progress note dated 08-26-2015, 09-23-2015 documents the injured worker is having ongoing pain in his neck, back and left wrist. He rates his pain as 9 out of 10 without meds and 7 out of 10 with meds. Relafen was not working and the injured worker stopped it. He takes Amitriptyline and it helps some. He is not sleeping well on his current mattress. It is difficult to help him sleep with medications. On 07-01-2015 he has left palm, wrist, finger, and sternal pain. He has severe pain in his low back and mid to upper lumbar area with radiation to the top of his right hip and down the right lower extremity. His neck is sore and stiff. He rates his overall pain a 8 out of 10. He continues to have a hard time sleeping. In a physician note dated 06-08-2015 documents there has been no improvement in his mid and low back pain which he rates as 9 out of 10 without meds and baseline pain is 5-7 out of 10. Treatment to date has included diagnostic studies, medications, therapy, home exercises, status post ORIF left wrist 03-14-2015 and hardware removal on 05-12-2015, and use of a back brace and wrist brace. Current medications include Norco (04-23-2015) and Amitriptyline. The Request for Authorization dated 10-01-2015 includes Norco 10/325 MG #150 and a replacement mattress. On 10-09-2015 Utilization Review

modified the request for Norco 10/325 MG #150 to Norco 10/325 MG #84. Utilization Review denied the request for a replacement mattress.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Norco 10/325 MG #150:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

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

**Decision rationale:** When to Continue Opioids: (a) If the patient has returned to work; (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is documented significant decrease in objective pain measures such as VAS scores for significant periods of time with pain reduced from a 9/10 to a 7/10. There are no objective measures of improvement of function or how the medication improves activities. The work status is not mentioned. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.

**Replacement Mattress:** 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.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) durable medical equipment.

**Decision rationale:** The California MTUS and the ACOEM do not specifically address the requested item. Per the Official Disability Guidelines section on durable medical equipment, DME is primarily and customarily used to serve a medical purpose and generally not useful to a person in the absence of illness or injury. DME equipment is defined as equipment that can withstand repeated use i.e. can be rented and used by successive patients, primarily serves a medical function and is appropriate for use in a patient's home. The equipment itself is not rentable or able to be used by successive patients. It does not serve a primary medical purpose that cannot be accomplished without it. The ODG also does not recommend mattresses for the treatment of back or neck pain. Therefore criteria have not been met per the ODG and the request is not medically necessary.