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| <b>Case Number:</b>   | CM15-0217184 |                              |            |
| <b>Date Assigned:</b> | 11/06/2015   | <b>Date of Injury:</b>       | 07/09/2002 |
| <b>Decision Date:</b> | 12/22/2015   | <b>UR Denial Date:</b>       | 10/26/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/04/2015 |

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 71 year old female with a date of injury on 7-9-02. A review of the medical records indicates that the injured worker is undergoing treatment for chronic thoracic, low back and bilateral leg pain. Progress report dated 10-8-15 reports continued complaints of pain rated 9 out of 10 without medication and 7 out of 10 with medications. She states that current pain medication regimen, activity restriction and rest help keep the pain manageable. Objective findings: thoracic and lumbar spine with mild tenderness to palpation, lumbar range of motion flexion 80 percent restricted, unable to extend and lateral bending is 80 percent restricted. Diagnostic studies noted. CT lumbar spine 9-10-15 revealed mild chronic T12 and L1 simple compression fractures, trace degenerative L2-3 degenerative retrolisthesis, severe T12-L1 disc space narrowing with end-plate sclerosis has progressed, moderate bilateral L1-2 and L2-3 foraminal stenosis. Treatments include: medication, laminectomy in 2001, fusion in 2006 and 2008, spinal cord stimulator implant 2011. Request for authorization dated 10-13-15 was made for Norco 10-325 mg quantity 90, Wheelchair for lower back pain, Scooter for lower back pain. Utilization review dated 10-26-15 non-certified the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

**Decision rationale:** Based on the 10/08/15 progress report provided by treating physician, the patient presents with chronic thoracic, low back and bilateral leg pain. The patient is status post laminectomy in 2001, and fusion in 2006 and 2008. The request is for Norco 10/325mg #90. RFA dated 10/13/15 was provided. Patient's diagnosis on 10/08/15 included postlaminectomy syndrome of lumbar region, degeneration of lumbar or lumbosacral intervertebral disc, chronic low back pain, and thoracic back pain. The patient ambulates with a walker. Physical examination of the lumbar spine on 10/08/15 revealed tenderness to palpation and decreased range of motion, especially on extension with 80% restriction. Positive straight leg raise test and constant hypoesthesia to bilateral legs to feet. Treatment to date has included surgery, imaging studies, spinal cord stimulator implant in 2011, physical therapy and medications. Patient's medications include Norco, Gabapentin, Prozac and Prilosec. Patient's work status not provided. MTUS, Criteria for Use of Opioids Section, pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS, Criteria for Use of Opioids Section Section, page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS, Criteria for Use of Opioids Section, p77, states that "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." MTUS, Medications for Chronic Pain Section, page 60 states that "Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity." MTUS p90 states, "Hydrocodone has a recommended maximum dose of 60mg/24 hrs." MTUS, Opioids for Chronic Pain Section, pages 80 and 81 states "There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant radiculopathy," and for chronic back pain, it "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited." Norco has been included in patient's medications per progress reports dated 02/17/15, 07/30/15 and 10/08/15. It is not known when this medication was initiated. Per 06/25/15 report, treater states "the patient denies any side effects or aberrant behavior with medications at this time. Patient reports that the benefit of chronic pain medication maintenance regimen, activity restriction, and rest continue to keep pain within a manageable level to allow patient to complete necessary activities of daily living..." UDS dated 08/12/14 was provided, which demonstrated consistent results. MTUS requires appropriate discussion of the 4As when opioid medications are prescribed. In this case, treater has addressed most of the 4A's, however specific examples of activities of daily living demonstrating significant functional improvement have not been provided. MTUS states that "function should include social, physical, psychological, daily and work activities." In addition, MTUS does not clearly support chronic opiate use for this kind of condition, chronic low back pain and

radiculopathy. It also appears this patient has been prescribed narcotic medications long term, and is not presumed to be suffering from nociceptive pain. Long-term use of opiates may in some cases be indicated for nociceptive pain according to MTUS, which states "Recommended as the standard of care for treatment of moderate or severe nociceptive pain (defined as pain that is presumed to be maintained by continual injury with the most common example being pain secondary to cancer)." While this patient presents with significant chronic complaints, without evidence of an existing condition which could cause nociceptive pain (such as cancer), continuation of this medication is not appropriate. Therefore, the request IS NOT medically necessary.

**Wheelchair for lower back pain:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC.

**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, under Wheelchair.

**Decision rationale:** Based on the 10/08/15 progress report provided by treating physician, the patient presents with chronic thoracic, low back and bilateral leg pain. The patient is status post laminectomy in 2001, and fusion in 2006 and 2008. The request is for Wheelchair for lower back pain. RFA dated 10/13/15 was provided. Patient's diagnosis on 10/08/15 included postlaminectomy syndrome of lumbar region, degeneration of lumbar or lumbosacral intervertebral disc, chronic low back pain, and thoracic back pain. Treatment to date has included surgery, imaging studies, spinal cord stimulator implant in 2011, physical therapy and medications. Patient's medications include Norco, Gabapentin, Prozac and Prilosec. Patient's work status not provided. ODG Knee and Leg chapter, under Wheelchair has the following: "Recommend manual wheelchair if the patient requires and will use a wheelchair to move around in their residence, and it is prescribed by a physician. Reclining back option recommended if the patient has a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day. Elevating leg rest option recommended if the patient has a cast, brace or musculoskeletal condition, which prevents 90-degree flexion of the knee, or has significant edema of the lower extremities. Adjustable height armrest option recommended if the patient has a need for arm height different than that available using non-adjustable arms. A light weight wheelchair is recommended if the patient cannot adequately self-propel (without being pushed) in a standard weight manual wheelchair, and the patient would be able to self-propel in the lightweight wheelchair." Physical examination of the lumbar spine on 10/08/15 revealed tenderness to palpation and decreased range of motion, especially on extension with 80% restriction. Positive straight leg raise test and constant hypoesthesia to bilateral legs to feet. This patient is status post multiple surgeries and ambulates with a walker. Given the patient's diagnosis and continued symptoms, this request appears reasonable. Therefore, the request IS medically necessary.

**Scooter for lower back pain:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Power mobility devices (PMDs).

**Decision rationale:** Based on the 10/08/15 progress report provided by treating physician, the patient presents with chronic thoracic, low back and bilateral leg pain. The patient is status post laminectomy in 2001, and fusion in 2006 and 2008. The request is for Scooter for lower back pain. RFA dated 10/13/15 was provided. Patient's diagnosis on 10/08/15 included postlaminectomy syndrome of lumbar region, degeneration of lumbar or lumbosacral intervertebral disc, chronic low back pain, and thoracic back pain. Treatment to date has included surgery, imaging studies, spinal cord stimulator implant in 2011, physical therapy and medications. Patient's medications include Norco, Gabapentin, Prozac and Prilosec. Patient's work status not provided. MTUS Chronic Pain Medical Treatment Guidelines, page 99, under "Power mobility devices (PMDs)" states "Not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care." Physical examination of the lumbar spine on 10/08/15 revealed tenderness to palpation and decreased range of motion, especially on extension with 80% restriction. Positive straight leg raise test and constant hypoesthesia to bilateral legs to feet. The patient ambulates with a walker. In this case, there are no abnormal neurological findings, loss of strength, or other functional deficit to the upper extremities, and no discussion of a lack of caregiver assistance. MTUS does not support the issuance of motorized wheelchairs in patients with sufficient upper extremity function to propel a standard wheelchair. Without demonstrated upper extremity deficit or discussion as to why this patient does not receive caregiver assistance, the requested motorized wheelchair cannot be substantiated. In addition, the concurrent request for a manual wheelchair has been recommended for authorization. Therefore, the request IS NOT medically necessary.