

<b>Case Number:</b>	CM15-0058279		
<b>Date Assigned:</b>	04/03/2015	<b>Date of Injury:</b>	10/27/2003
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2015

### 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, Arizona

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:

The injured worker is a 59-year-old female, who sustained an industrial injury on 10/27/2003. The diagnoses have included lumbosacral spine degenerative disc disease; lower extremity radiculopathy; and bilateral knee chondromalacia. Treatment to date has included medications, diagnostic studies, acupuncture, physical therapy, and home exercise program. Medications have included Norco and Flector patches. A progress note from the treating physician, dated 10/09/2014, documented a follow-up visit with the injured worker. Currently, the injured worker complains of continued pain, discomfort in the lower back, and lower extremities. Objective findings included ambulation with a walker; discomfort in the lower back paraspinal muscles and the anterior knees bilaterally; and discomfort with straight leg raise testing. The treatment plan has included the request for Norco 10/325 mg #60; Flector patch #30; Treatment nurse; Home evaluation modification; and Vehicle hand control modification. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 74-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed to respond to non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized the above medication for an unknown duration. There is no documentation of objective functional improvement. There is no evidence of a written consent or agreement for chronic use of an opioid. Recent urine toxicology reports documenting evidence of patient compliance and non-aberrant behavior were not provided. There was also no frequency listed in the request. Given the above, the request is not medically necessary.

**Flector patch #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**Decision rationale:** California MTUS Guidelines state the only FDA approved topical NSAID is diclofenac, which is indicated for the relief of osteoarthritis pain. The injured worker has continuously utilized the above medication for an unknown duration. There is no documentation of objective functional improvement. There is also no specific frequency or strength listed in the request. Given the above, the request is not medically necessary.

**Treatment nurse:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health services.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

**Decision rationale:** California MTUS Guidelines recommend home health services only for otherwise recommended medical treatment for patients who are homebound on a part time or intermittent basis, generally up to no more than 35 hours per week. In this case, the specific type of services required was not listed. There was no specific frequency or total duration of treatment listed in the request. Given the above, the request is not medically necessary.

**Home evaluation modification:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health services.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

**Decision rationale:** California MTUS Guidelines recommend home health services only for otherwise recommended medical treatment for patients who are homebound on a part time or intermittent basis, generally up to no more than 35 hours per week. In this case, the specific type of services required was not listed. There was no specific frequency or total duration of treatment listed in the request. Given the above, the request is not medically necessary.

**Vehicle hand control modification:** 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), Durable medical equipment (DME).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Durable Medical Equipment.

**Decision rationale:** The Official Disability Guidelines state durable medical equipment is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. Medical conditions that result in physical limitations may require patient education and modification to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature. Therefore, the requested durable medical equipment cannot be determined as medically appropriate in this case. As such, the request is not medically necessary.