

Case Number:	CM15-0172602		
Date Assigned:	09/14/2015	Date of Injury:	07/19/2000
Decision Date:	10/13/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/01/2015

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: Arizona, California
 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 (IW) is a 54-year-old female who sustained an industrial injury on 07-19-2000. She reported pain in the back, right hip, and legs. The injured worker was diagnosed as having Lumbago, low back pain, Lumbar Spinal Stenosis, and a Spinal cord injury. Treatment to date has included pain management, and durable medical equipment. In the August 3, 2015 visit, the injured worker has continued right hip pain that is constant. She has pain that she rates as a 7 on a scale of 10 with medication. She complains of pain in the back, hips and legs, incontinence, stiffness, joint problems, fatigue, muscle weakness, insomnia, anxiety and depression. She relates that she is unable to participate in activities of daily living, related to shopping, laundry, gardening, driving. The worker ambulates with a walker, is able to bathe and dress herself and do oral hygiene. Her current medications include Methadone, Norco, Ditropan, Neurontin, and Xanax and X-viate 40% topical cream. The worker is incontinent of urine and needs briefs to cope with the incontinence. According to the provider notes: "Her scooter is old and broken and is not worth fixing. She needs a new scooter. Her bed needs a new remote control device." The plan of care is to request these items and continued pain medications. A request for authorization was submitted for a prospective request for Norco 10/325 mg, #180, a prospective request for depends briefs # 1, a prospective request for a New Scooter # 1, a prospective request for a New Remote control device for bed . A utilization review decision (08- 27-2015) modified the request for Norco to certify 1 prescription of Norco 10/325 mg to #90 between 08-03-2015 and 10-25-2015, Certified the request for 1 depends briefs between 08-03- 2015 and 10-25-2015, non-

certified the prospective request for a New Scooter # 1, between 08-03-2015 and 10-25-2015, and non-certified the prospective request for a New Remote control device for bed between 08-03-2015 and 10-25-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg, #180: 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): Opioids for chronic pain, Opioids for neuropathic pain, Opioids, criteria for use, Opioids, dosing, Opioids, specific drug list.

Decision rationale: Norco is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Norco along with Roxycodone and Methadone for several months without significant improvement in pain or function. Use of multiple opioids along with Methadone is not recommended and there is no mention of detoxification while on Methadone. There was no mention of Tylenol, NSAID, Tricyclic or weaning failure. The claimant was on Methadone and Roxycodone for over 2 years. No one opioid is superior to another. The continued use of Norco is not medically necessary.

New Scooter # 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg, Power Mobility Devices.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Power mobility devices (PMDs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee chapter and pg.

Decision rationale: According to the guidelines, a scooter is 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. In this case, the claimant is able to ambulate with a walker. The claimant performs ADLS. The claimant only required the scooter for long distances, which is not a medical necessity. No indication that a scooter is required over other mobility devices. The request for a scooter is not medically necessary.

New Remote control device for bed # 1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) knee chapter-DME and pg 21 low back chapter and pg 63.

Decision rationale: The term DME is defined as equipment which: (1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients; (2) Is primarily and customarily used to serve a medical purpose; (3) Generally is not useful to a person in the absence of illness or injury; & (4) Is appropriate for use in a patient's home. According to the ODG guidelines, mattress selection is not recommended. The request for a remote control for the bed is not primarily medical in nature and can be used by a person without an injury. Particular need was not justified. The request for the remote is not medically necessary.