

<b>Case Number:</b>	CM13-0069132		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	09/21/1998
<b>Decision Date:</b>	04/21/2014	<b>UR Denial Date:</b>	12/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/20/2013

### 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 Orthopedic Surgery and is licensed to practice in Texas. 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 patient is a 67-year-old female who reported a work related injury on September 21, 1998. Her diagnoses include postlaminectomy lumbar syndrome and lumbar disc disorder. According to recent clinical notes, the patient complained of lower backache and numbness over both feet. Physical exam revealed range of motion was restricted with extension limited to 5 degrees by pain and straight leg raise test was positive on the left side. Motor strength of right lower extremities is 5-/5 on the right and 5/5 on the left. She reported she was not trying any other therapies for pain relief. The patient reported her medications were working well. Her current medications include Provigil 200mg, Hytrin 1mg, hydromorphone PF, Clonidine PF, and Bupivacaine PF for IT pump use, Lidoderm 5% patch, Dilaudid 4mg, AcipHex 20mg, Amrix 15mg, hydrochlorothiazide 12.5mg, and lisinopril 10mg. A request has been made for Dilaudid 4mg, #90, and an ergonomic task chair for home use, reporting that her own chair has exacerbated her low back pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**AN ERGONOMIC TASK CHAIR:** Upheld

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

**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 Chapter, Knee and Leg Chapter, Ergonomics interventions

**Decision rationale:** The Official Disability Guidelines state that ergonomic interventions are recommended as an option as part of a return to work program for injured workers, but there is conflicting evidence for prevention, so case-by-case recommendations are necessary. This study concluded that there was no good quality evidence on the effectiveness of ergonomics or modification of risk factors in prevention of low back pain. Per clinical documentation submitted for review, the patient was not noted to be returning to work. The request for an ergonomic task chair was for home use for the patient. In addition, durable medical equipment is defined as equipment that is primarily and customarily used to service a medical purpose. Guidelines state that there is no evidence on the effectiveness of ergonomics in the prevention of lower back pain; therefore, there is no evidence given an ergonomic task chair would serve a medical purpose for the patient, per guideline criteria for durable medical equipment. As such, the request for Ergonomic Task chair is non-certified.

**DILAUDID 4MG, #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-going management Page(s): 78-80.

**Decision rationale:** Per recent clinical documentation submitted for review, the patient's medications include Dilaudid as needed for pain. It was reported the patient was stable on her current medication regimen and had not changed essential regimen in greater than six (6) months. The patient's function and activities of daily living were improved optimally on current doses of medications and the pain agreement was briefly reviewed with the patient. The California Medical Treatment Guidelines for Chronic Pain state that a patient's satisfactory response to treatment with opioids may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The clinical documentation submitted for review did not give evidence the patient had any objective significant relief or functional improvements as a result of the use of Dilaudid. There was no pain scales reported for the patient in which she noted her pain before and after taking medications with an objective decrease in Visual Analog Scales due to the use of Dilaudid. There were no functional benefits noted for the patient that could be objectively measured due to the use of Dilaudid. Therefore, the request for Dilaudid 4mg, #90 is non-certified.