

<b>Case Number:</b>	CM14-0004550		
<b>Date Assigned:</b>	02/05/2014	<b>Date of Injury:</b>	06/02/1978
<b>Decision Date:</b>	07/02/2014	<b>UR Denial Date:</b>	12/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California. 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 73 year-old female who has filed a claim for osteoarthritis of the lower leg, displacement of lumbar intervertebral disc, and lumbosacral radiculopathy associated with an industrial injury date of June 02, 1978. Review of progress notes from July and August 2013 reports low back pain radiating to the mid-back. There is numbness and tingling of bilateral feet, more on the left. The left knee has severe pain and swelling, and the right knee has pain with occasional swelling. The right third and fourth toes have mild pain and morning stiffness. Findings include tenderness over bilateral posterior superior iliac spine, and moderate joint effusion of the left knee. Treatment to date has included Tylenol, opioids, ice and heat packs, Flector patches, injections to the left knee, injections to the posterior superior iliac spine, total knee replacement of the left knee in 2003, and lumbar surgery in 1979. Utilization review from December 06, 2013 denied the request for Nexium 40mg #30 with 5 refills as documentation does not provide support for continued use; Tylenol ES #120 with 5 refills as there is no documentation regarding ongoing efficacy and side effects monitoring; adjustable bed as there is no stated rationale for this request; electric lift recliner as there is no information regarding a formal therapy assessment to support this equipment; and cortisone injection - Depo Medrol 40mg (07/16/13) as information provided does not meet support for this procedure. Ultracet 37.5/325mg was modified for #75, as benefits of medication were not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ULTRACET 37.5/325MG, #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-84.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

**Decision rationale:** As noted on page 78-81 of the CA MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Patient has been on this medication since at least June 2012. There is no documentation regarding symptomatic improvement or objective functional benefits derived from this medication. There is also no documentation regarding periodic urine drug screens to monitor medication use. Therefore, the request for Ultracet 37.5/325mg #120 was not medically necessary.

**TYLENOL ES, #120 WITH 5 REFILLS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 9, 11-12.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 11-12.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines pages 11-12 state that Acetaminophen is indicated for treatment of chronic pain & acute exacerbations of chronic pain. Patient has been on this medication since at least June 2012. Progress notes indicate that the medications are taking the edge off. Medications are not helping the left knee pain, only the back pain. This patient has been on chronic acetaminophen and Ultracet, which contains acetaminophen. There is no documentation regarding side-effect monitoring, and of significant benefits derived from this medication. Therefore, the request for Tylenol ES #120 with 5 refills was not medically necessary.

**NEXIUM 40MG, #30 WITH 5 REFILLS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**Decision rationale:** According to page 68 of CA MTUS Chronic Pain Medical Treatment Guidelines, proton pump inhibitors are used in patients on NSAID therapy who are at risk for GI events. Risk factors include age > 65; history of peptic ulcer, GI bleed, or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; and high dose or multiple NSAID use. Use of PPI > 1 year has been shown to increase the risk of hip fracture. In this case, chronic anti-inflammatory use resulted in chronic gastritis, for which the patient notes relief with Nexium over other proton pump inhibitors. Patient has been on this medication since at least June 2012. There is no documentation that this patient is currently on NSAID therapy, or of any recent gastrointestinal symptoms. Therefore, the request for Nexium 40mg #30 with 5 refills was not medically necessary.

**ELECTRIC LIFT RECLINER: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physical Medicine & Rehabilitation, Principles and Practice. Ed DeLisa JA. 4th Edition, Lipincott, 2006, Chapter 43, pg. 975.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin: Therapeutic chairs [http://www.aetna.com/cpb/medical/data/400\\_499/0434.html](http://www.aetna.com/cpb/medical/data/400_499/0434.html).

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and Aetna was used instead. According to Aetna, posture support chairs are medically necessary when they provide support for physically handicapped persons with impaired head and trunk control due to weakness or spasticity. In this case, the patient uses a recliner to sleep 75% of the time. The patient is unable to use a traditional recliner due to the inability to lean forward or push and pull on the lever without experiencing low back strain. Patient already has an adjustable bed. There is no documentation regarding weakness or spasticity in this patient. There is also no indication as to why another recliner is necessary in this patient. Therefore, the request for electric lift recliner was not medically necessary.

**RETRO: CORTISONE INJECTION-DEPO MEDROL 40MG, 7/16/13: 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), Treatment Index, 11th Edition (web), 2013, Hip and Pelvis Chapter, intra-articular steroid hip injection (IASHI).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis chapter, Intra-articular steroid hip injection (IASH).

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, intra-articular steroid hip injections are not recommended in early hip osteoarthritis. They are under study for moderately advanced or severe hip OA. If used, they should be in conjunction with fluoroscopic guidance. They are recommended as an option for short-term pain relief in hip trochanteric bursitis or greater trochanteric pain syndrome (GTPS). In this case, the patient had previous injection to the posterior superior iliac spine in September 2012. There was no documentation regarding the benefits derived from this. Also, there is no documentation regarding trochanteric bursitis or hip osteoarthritis. Findings only note tenderness of bilateral posterior superior iliac spine. Therefore, the retrospective request for cortisone injection - Depo Medrol 40mg (07/16/13) was not medically necessary.

**ADJUSTABLE BED: 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),

Treatment Index, 11th Edition (web), 2013, Low Back Chapter, Mattress Selection.

**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, Mattress selection.

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, it is not recommended to use firmness as a sole criteria for mattress selection. In this case, the patient was provided an adjustable bed around 15 years ago, and the mattress has now worn thin. Patient is unable to lie flat and has to change positions multiple times throughout the night. However, there is no documentation regarding the benefits derived from use of an adjustable bed. Also, there is no indication for a new adjustable bed as only the mattress has worn thin. There are no high-quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. Therefore, the request for adjustable bed was not medically necessary.