

Case Number:	CM14-0043143		
Date Assigned:	07/07/2014	Date of Injury:	11/05/2008
Decision Date:	08/22/2014	UR Denial Date:	04/02/2014
Priority:	Standard	Application Received:	04/10/2014

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 Physical Medicine & Rehabilitation 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 56 year old male with date of injury 11/5/08. The treating physician report dated 3/14/14 indicates that the patient presents with chronic lumbar pain affecting primarily the right lower extremity and the pain is a 10/10. Additionally the patient complains of bilateral upper extremity, bilateral hip, bilateral feet, bilateral buttocks, bilateral knee, neck and head pain. The patient has difficulty sleeping due to his severe pain. The patient uses an intrathecal pump as well as a walker and wheel chair as assistive device. The current diagnoses are: 1.Lumbar IVD syndrome2.Edema3.Peripheral neuropathy4,Lumbrosacral spondylosis without myelopathyThe patient had also been diagnosed with venous insufficiency and lymphedema in both legs secondary to his industrially related injury, which progressed to cellulitis and infection of the right lower leg in January 2014, requiring hospitalization.The utilization review report dated 4/1/14 denied the request for one full size orthopedic bed with new mattress and modified one prescription for Roxicodone based on the MTUS guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 FULL SIZE ORTHOPEDIC BED WITH NEW MATTRESS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, LOW BACK - LUMBAR & THORACIC (ACUTE & CHRONIC).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) lumbar chapter.

Decision rationale: The patient presents with chronic severe pain affecting the lumbar spine and right lower extremity and is status post hospitalization for right lower extremity cellulitis and infection. The current request is for one full size orthopedic bed with new mattress. The treating physician report dated 3/14/14 states, "Request for full size orthopedic bed with new mattress. The treating physician notes that the patient has significant erythematous changes without pitting edema and has severe cellulitis. There is no information provided to explain why the patient requires an orthopedic bed with new mattress. The MTUS and ODG guidelines do not address orthopedic beds and the ODG guidelines state that there are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. The AETNA guidelines do not support ordinary non hospital beds. There is no clinical explanation provided in the records provided to explain why an orthopedic bed and new mattress are required for this patient and the ODG and AETNA guidelines do not support this request. Recommendation is for denial.

1 PRESCRIPTION FOR ROXICODONE 15MG #240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids for chronic pain pg 80-82

Decision rationale: The patient presents with chronic severe pain affecting the lumbar spine and right lower extremity and is status post hospitalization for right lower extremity cellulitis and infection. The current request is for Roxicodone 15mg #240. The patient is currently prescribed Megace, Aciphex, Neurontin, Lorazepam, Linzess, Soma, Zanaflex, Allbuterol sulfate, Advair, Spiriva, Dallresp, Klor-Con, Aldactone, Bumetanide, Lasix, Colace, Trazodone, Oxycontin and Roxicodone. The treating physician states, "His pain gets better by nothing. Patient notes no alleviating factors." The utilization review report dated 4/1/14 modified the request for Roxicodone to allow for tapering and discontinuation of Roxicodone. The MTUS guidelines for opioid usage requires documentation of pain and functional improvement compared to baseline. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument. MTUS further requires documentation of the four A's (analgesia, ADL's, adverse side effects, adverse behavior). The MTUS guidelines require thorough documentation of the functional benefits of chronic opioid usage. In this case the treating physician has stated that nothing helps alleviate the patient's symptoms and there is no reported functional relief with the ongoing usage of Roxicodone. Recommendation is for denial of Roxicodone and follow the UR recommendations of tapering for discontinuation.

