

<b>Case Number:</b>	CM14-0043862		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	11/22/2006
<b>Decision Date:</b>	08/25/2014	<b>UR Denial Date:</b>	04/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	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 and Rehabilitation and is licensed to practice in Illinois. 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 injured worker is a 38-year-old male with a reported date of injury on 11/22/2006. The mechanism of injury was noted to be a motor vehicle accident. His diagnoses were noted to include left hip pain, tingling of left foot, mechanical left back pain, and chondromalacia of the left knee. His previous treatments were noted to include TENS unit, chiropractic care, physical therapy, massage, and a home exercise program. The Progress Note dated 03/11/2014 revealed the injured worker complained of pain to his hip and back. The injured worker indicated his leg pain was worse than the right and he had a Charlie horse sensation on the sole of the left foot. The injured worker indicated he had moderate to severe pain in the lower back with pain radiating from the back to the la. The physical examination to the lumbar spine noted limited flexion and the S1 had a limitation of extension, lateral flexion and rotation. There was a bilateral positive straight leg raise. The motor strength testing revealed mild weakness to the quadriceps and abductors on the left. The Request for Authorization form dated 03/19/2014 was for a gel seat cushion for ongoing hip pain. The Request for Authorization Form was not submitted with the medical records for Norco 10/325 mg #60 with 2 refills for pain and ice TENS heat in the form of Thermacare wraps for back pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 gel seat cushion:** 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 and Leg, Durable Medical Equipment.

**Decision rationale:** The injured worker has had previous total hip replacement surgery. The Official Disability Guidelines recommend durable medical equipment generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. Most bathroom and toilet supplies do not customarily serve a medical purpose and are primarily used for convenience in the home. Medical conditions that result in physical limitations for patients may require patient education and modification to the home environment for prevention of injury, but environmental modifications are not considered primarily medical in nature. Certain durable medical equipment (DME) toilet items such as commodes and bedpans are medically necessary if the patient is bed or room confined and devices such as raised toilet seats, commode chairs, Sitz baths, and portable whirlpools may be medically necessary when prescribed as part of a medical treatment plan for injury, infection, or conditions that result in physical limitations. The term DME is defined as equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally not useful to a person in the absence of illness or injury, and is appropriate for use in the patient's home. A gel seat cushion is not medically necessary and does not serve a medical purpose since it is used for comfort. Therefore, the request is not medically necessary and appropriate.

**Norco 10/325 mg #60 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

**Decision rationale:** The injured worker's been utilizing this medication since 04/2012. According to the California Chronic Pain Medical Treatment Guidelines, the ongoing use of opioid medications may be supported with detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines also state that the 4 A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors, should be addressed. There is a lack of documentation regarding evidence of decreased pain on a numerical scale with the use of medications. The documentation provided the injured worker was able to stand 10 to 15 minutes with and without medications and can lift his son with care. No adverse effects with the use of medications were noted. The documentation indicated the injured worker has not shown any aberrant drug taking behaviors; however, it is unclear as to whether the injured worker has had consistent urine drug screens and when the last test was performed. Therefore, despite the evidence of increased functional status without documentation regarding significant pain relief, adverse effects, and without details regarding urine drug testing to verify appropriate medication use in the absence of aberrant

behavior, the ongoing use of opioid medications is not supported by the guidelines. Additionally, the request failed to provide the frequency at which this medication is to be utilized. The request is not medically necessary and appropriate.

**1 Ice Tns heat in the form of Thermacare wraps: Upheld**

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

**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, Cold/heat packs.

**Decision rationale:** The injured worker has low back pain and uses a hot water pack to make it feel better. The Official Disability Guidelines recommend at home local applications of cold packs in the first few days of acute complaints; thereafter, applications of heat packs or cold packs. Continuous flow level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The evidence for the application of cold treatment to the low back pain is more limited than heat therapy, with only 3 poor quality studies located that support its use, but studies confirm that it may be a low risk, low cost option. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. The guidelines recommend cold applications for the first few days of acute complaints and heat applications thereafter. The request does not specify if it is for hot or cold and more detailed information is needed. Therefore, the request is not medically necessary and appropriate.