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| <b>Case Number:</b>   | CM15-0147336 |                              |            |
| <b>Date Assigned:</b> | 08/10/2015   | <b>Date of Injury:</b>       | 04/24/2001 |
| <b>Decision Date:</b> | 09/09/2015   | <b>UR Denial Date:</b>       | 07/23/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 07/29/2015 |

### 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: Texas, 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:

April 24, 2001; the injury was sustained when the injured worker slipped on a wet floor, causing a dislocation of the left knee. The injured worker fell on the floor landing on the right elbow. The injured worker previously received the following treatments lumbar spine CT scan without contrast which showed bilateral degenerative sacroilitis without acute fracture or subluxation on July 21, 2015, Lyrica, Cymbalta, Endocet, Colace, Lunesta, Amrix ER, Diltiazem, Levothyroxine, failed Toradol, spinal cord stimulator implant. The injured worker was diagnosed with regional pain syndrome, 2-3 arthroscopic left knee surgeries; status post left knee replacement, pain in the joint of the lower leg, knee pain, elbow pain and RSD of the upper limb. According to progress note of July 1, 2015, the injured worker's chief complaint was abdominal and tail bone pain. The injured worker rated the pain at 7 out of 10 with medications with poor quality of sleep. The injured worker's activity level remained the same. The physical exam noted the injured worker to be anxious, in moderate pain and tearful. The injure worker had a global antalgic gait and assistance of a cane. The examination of the left knee noted tenderness over the quadriceps tendon. There was a moderate effusion in the left knee joint. There was restricted range of motion in the left knee. There was tenderness with palpation of the right elbow over the lateral epicondyle, medial epicondyle and swelling at the medial epicondyle of the elbow. There were trigger points with radiation of pain and twitching response to palpation at the lumbar paraspinal muscles on the left and right. The treatment plan included a tempor-ergo premier adjustable foundation (king size) and CT scan to rule out lumbar and sacral fracture and herniation. The medication list includes Lyrica, Cymbalta, Endocet, Colace, Lunesta, Amrix ER,

Diltiazem, and Levothyroxine. The patient has had a BMI of 41.6. The patient has had an X-ray of the lumbosacral spine on 3/13/15 that revealed degenerative changes. The patient has had history of spinal cord stimulator and removal. The patient has had a lumbar spine CT scan without contrast which showed bilateral degenerative sacroilitis without acute fracture or subluxation on July 21, 2015. The patient sustained the injury due to slip and fall incident. The patient's surgical history includes left TKR in 2012. The patient had received an unspecified number of the PT visits for this injury.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **One (1) Tempur-ego premier adjustable foundation (king size): 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), Low Back, Lumbar and Thoracic Chapter: Mattress selection.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 07/17/15) Mattress selection Lumbar supports.

**Decision rationale:** One (1) Tempur-ego premier adjustable foundation (king size) - As per cited guideline "Not recommended to use firmness as sole criteria; "There are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain". On the other hand, pressure ulcers (e.g., from spinal cord injury) may be treated by special support surfaces (including beds, mattresses and cushions) designed to redistribute pressure". Evidence of the pressure ulcers was not specified in the records provided. Evidence of compression fractures, spondylolisthesis, instability, or a recent surgery is not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. Response to this conservative therapy was not specified in the records provided. Prior conservative therapy notes were not specified in the records provided. A recent PT note documenting any significant functional deficit of the lumbar spine that would require a special foundation for the bed, was not specified in the records provided. Evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. The medical necessity of the request for One (1) Tempur-ego premier adjustable foundation (king size) is not fully established in this patient and therefore is not medically necessary.

#### **One (1) CT scan: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 59.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) CT (computed tomography) Low Back (updated 03/24/15).

**Decision rationale:** Per the ACOEM low back guidelines cited below "If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures)". In addition per the ODG guidelines lumbar CT is "Not recommended except for indications of lumbar spine trauma, with neurological deficit, with seat belt fracture; myelopathy traumatic, infectious disease patient; evaluate pars not identified by plain X-rays". The patient has had a lumbar spine CT scan without contrast which showed bilateral degenerative sacroilitis without acute fracture or subluxation on July 21, 2015. Significant changes in objective physical examination findings since the last imaging that would require a repeat study were not specified in the records provided. Repeat studies are reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neuro-compression, recurrent disc herniation). These indications for lumbar spine CT scan without contrast were not specified in the records provided. Patient did not have any progressive neurological deficits that are specified in the records provided. Findings suspicious for tumor, infection, fracture, neurocompression, or other red flags were not specified in the records provided. The patient had received an unspecified number of PT visits for this injury. Prior PT visits notes were not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. The medical necessity of the request for CT scan is not fully established in this patient and therefore is not medically necessary.