

<b>Case Number:</b>	CM13-0034013		
<b>Date Assigned:</b>	12/06/2013	<b>Date of Injury:</b>	10/17/2002
<b>Decision Date:</b>	01/24/2014	<b>UR Denial Date:</b>	09/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/11/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Psychiatry, Child and Adolescent Psychiatry 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 physician 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 65-year-old female with a reported date of injury on 10/17/2002. The patient presented with pain in the low back, right hip pain, radiating pain to the right anterior hip into the groin and buttock area, intermittent numbness in the right leg, neck pain, bilateral shoulder pain, left knee pain, headaches mostly in the occipital area and the paracentral region radiating to the occipital area, recurrent fall due to chronic low back, hip, and knee difficulties, moderate spasm in the lumbar spine, decreased lumbar spine range of motion, and decreased sensation in the right thumb and index finger on the right side as compared to the left. It was noted the patient's pain was not well controlled even with the morphine that she was utilizing. The patient had diagnoses including status post fall 10/17/2002, lumbar strain, right lumbar radiculopathy, cervical strain, status post fusion on 10/17/2003 with residual cervical pain, status post right hip surgery on 01/06/2006 with residual right hip pain, left hip pain, left knee strain, status post total knee replacement on 08/24/2007, right shoulder strain with impingement, status post right shoulder surgery on 10/06/2008, left shoulder strain, status post left shoulder arthroscopic surgery on 03/16/2009, depression, cervicogenic headaches, and unrelated fracture of the right femur, resolved. The physician's treatment plan included a request for a home health aide, a request for a TENS unit, request for a wheeled walker with a seat, a request for pain management consult, a request for Skelaxin 800 mg #60, a request for Norco 10/325 mg #120, a request for morphine sulfate 15 mg #60, a request for Medrox cream 120 gm, and a request for ThermaCare heat patches #60.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home Health Aide:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51. Decision based on Non-MTUS Citation ODG), Low Back chapter & www.medicare.gov.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

**Decision rationale:** The California MTUS guidelines note home health services are recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. Per the provided documentation, it was noted the home health aide would be required to help in the patient's home with laundry, housekeeping, grocery shopping, and with any other tasks that required more strength or endurance than the patient was able to manage. Per the provided documentation, it did not appear the home health aide would be required to perform medical treatment, and the aide would only be used for homemaker services. Therefore, the request for a home health aide is neither medically necessary nor appropriate

**TENS Unit i:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-1161.

**Decision rationale:** The California MTUS guidelines note the use of TENS is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration for patients with; neuropathic pain, CRPS II, CRPS I, spasticity, and/or multiple sclerosis. Per the provided documentation, the physician recommended the use of TENS for management of the patient's chronic pain. However, within the provided documentation it did not appear the had undergone a 1 month home based TENS trial with documented efficacy of the unit. Therefore, the request for a TENS unit is neither medically necessary nor appropriate

**Wheel walker w/seat:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare National Coverage Determinations Manual.

**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, Walking aids (canes, crutches, braces, orthoses and walkers).

**Decision rationale:** The California MTUS guidelines and ACOEM do not address the use of four wheeled walkers. The Official Disability Guidelines note almost half of patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid. Assistive devices for ambulation can reduce pain associated with osteoarthritis. Frames or wheeled walkers are preferable for patients with bilateral disease. Per the provided documentation, the patient's gait was slow and she was utilizing a single point cane to aid with ambulation. The provider recommended the use of a wheeled walker with a seat as needed. Per the provided documentation, the physician's rationale for the request was unclear. Additionally, the requesting physician did not include documentation that the patient's current ambulatory aid was insufficient. Therefore, the request for a wheeled walker with a seat is neither medically necessary nor appropriate.

**Pain Management Consult:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (chronic), Office visits.

**Decision rationale:** The California MTUS guidelines and ACOEM do not specifically address pain consultations. The Official Disability Guidelines note, evaluation and management (E&M), outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The provider recommended a pain management consultation to manage the patient's opioids and recommend additional treatment modalities. Per the provided documentation, it was noted the patient's pain was not well controlled even with morphine and the patient was still having difficulties with activities of daily living when just using morphine. Therefore, the request for a pain management consult would be reasonable in order to find an opioid to manage the patient's pain as well as additional treatment modalities. Therefore, the request for a pain management consult is medically necessary and appropriate.

**Skelaxin 800mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

**Decision rationale:** The California MTUS guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Per the provided documentation, it appeared the patient had been utilizing the medication since at least 09/19/2012. While the patient did have documentation of persistent moderate spasm in the lumbar spine, the use of muscle relaxants are recommended for short-term treatment of acute exacerbations in patients with chronic low back pain. The continued use of Skelaxin would exceed the guideline recommendations for short-term use. Additionally, the requesting physician did not include adequate documentation of significant objective functional improvement with the use of the medication. Therefore, the request for Skelaxin 800 mg #60 is neither medically necessary nor appropriate.

**Norco 10/325mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria Page(s): 78-80,81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

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

**Decision rationale:** The California MTUS guidelines recommend patients utilizing opioid medication should obtain prescriptions from a single practitioner, medications should be taken as directed, and all prescriptions should come from a single pharmacy. Providers should prescribe the lowest possible dose should be prescribed to improve pain and function. Provider should conduct ongoing review with documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. Within the provided documentation, the requesting physician did not include adequate documentation of significant objective functional improvement with the use of the medication. Additionally, the requesting physician did not include an adequate and complete assessment of the patient's pain, the least

reported pain over the period since the last assessment, average pain, intensity of the pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Therefore, the request for Norco 10/325 mg #120 is neither medically necessary nor appropriate.

**Medrox Cream 120gm: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111, 112-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Guidelines Analgesics and Salicylate Topicals Page(s): 111-113, 105.

**Decision rationale:** The Medrox cream consists of methyl salicylate, menthol, and capsaicin. The California MTUS Guidelines note topical salicylate is significantly better than placebo in chronic pain. The California MTUS Guidelines recommend the use of capsaicin for patients with osteoarthritis, postherpetic neuralgia, diabetic neuropathy, and post mastectomy pain. The guidelines recommend the use of capsaicin only as an option in patients who have not responded or are intolerant to other treatments. The guidelines state any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. Within the provided documentation, it did not appear the patient had a diagnosis that would coincide with the recommended usages of capsaicin. Additionally, the requesting physician did not include documentation of significant objective functional improvement with the use of the medication. Therefore, the request for Medrox cream 120 gm is neither medically necessary nor appropriate.

**Thermacare Heat Patches #60: 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 chapter.

**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 Pain, Heat Therapy.

**Decision rationale:** The California MTUS guidelines and ACOEM do not specifically address Thermacare heat wraps. The Official Disability Guidelines note heat therapy is recommended as an option. A number of studies show continuous low-level heat wrap therapy to be effective for treating low back pain. One study compared the effectiveness of the Johnson & Johnson Back Plaster, the ABC Warne-Pflaster, and the Procter & Gamble ThermaCare HeatWrap, and concluded that the ThermaCare HeatWrap is more effective than the other two. There is moderate evidence that heat wrap therapy provides a small short-term reduction in pain and disability in acute and sub-acute low-back pain, and that the addition of exercise further reduces pain and improves function. Heat therapy has been found to be helpful for pain reduction and return to normal function. Per the guidelines, it is noted ThermaCare heat wraps provide a small, short-term reduction in pain and disability in acute and subacute low back pain. Within the provided documentation, the requesting physician did not include adequate documentation of the

efficacy of the heat wraps, including objective functional improvement or reduction in pain. Therefore, the request for ThermaCare heat patches #60 is neither medically necessary nor appropriate.