MAXIMUS Federal Services

| Case Number: | CM13-0049600 | | |
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| Date Assigned: | 12/27/2013 | Date of Injury: | 04/18/2008 |
| Decision Date: | 05/22/2014 | UR Denial Date: | 09/20/2013 |
| Priority: | Standard | Application Received: | 11/08/2013 |

## 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 Orthopedic Surgery 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 injured worker is a 67-year-old female who reported an injury on 04/18/2008. The mechanism of injury was the injured worker was bending forward to retrieve a medicine bottle from a low shelf and felt a pop in the low back. The injured worker's medication history included Norco and Medrox as of 2012. The diagnoses indicate right lumbar radiculopathy and thoracic strain. The documentation of 07/10/2013 revealed the injured worker was continuing to use a wheeled walker. . The injured worker had a gait that was slow and antalgic due to low back pain. The injured worker had decreased range of motion and a positive straight leg raise bilaterally with slight to moderate muscle spasm of the paralumbar region and decreased strength in the right ankle. There was decreased sensation in the right big toe. The recommendation/ treatment was Norco 10/325 for pain control during flareups and Medrox as it had been helpful, Cymbalta 30 mg, continued use of the wheeled walker with a seat as needed, evaluation for a scooter due to the injured worker's chronic low back pain, weakness, and falling, supplies for an OrthoStim unit as it had been helpful, and to continue home exercise and stretching as tolerated.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**PURCHASE SCOOTER:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99..

**Decision rationale:** The California MTUS Guidelines do not recommend power mobility devices if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the injured worker has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. The clinical documentation submitted for review indicated the injured worker was utilizing a wheeled walker. There was lack of documentation indicating the injured worker did not have sufficient upper extremity function to propel a manual wheelchair, that there was a caregiver who was available, willing, and able to provide assistance with a manual wheelchair. It was indicated the request was due to the injured worker's chronic low back pain, weakness, and falling. Given the above and the lack of documentation of exceptional factors to warrant non adherence to guideline recommendations, the request for purchase of scooter is not medically necessary.

**PURCHASE SUPPLIES FOR ORTHO STIM UNIT:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118, 121.

**Decision rationale:** California MTUS guidelines do not recommend Neuromuscular electrical stimulation (NMES devices) as there is no evidence to support its' use in chronic pain. They do not recommend Interferential Current Stimulation (ICS) as an isolated intervention and galvanic stimulation is considered investigational for all indications. It is characterized by high voltage, pulsed stimulation and is used primarily for local edema reduction through muscle pumping and polarity effect and is not recommended. The clinical documentation submitted for review indicated the ortho stim unit was beneficial for the injured worker. However, there was lack of documentation of objective functional benefit that was received. There was lack of documentation of exceptional factors as neuromuscluar electrical stimulation is not recommended for chronic pain. Given the above and the lack of documentation, the request for purchase of supplies for OrthoStim unit is not medically necessary. The request as submitted failed to indicate what supplies were being requested.

**PURCHASE LIFT CHAIR FOR SCOOTER:** 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 & LEG CHAPTER, DME.

**Decision rationale:** Official Disability Guidelines recommend durable medical equipment if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. Durable medical equipment includes equipment which can withstand reported use or normally be rented, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in an injured worker's home. Lift chairs for scooters are not generally considered appropriate for use in the injured worker's home. The clinical documentation submitted for review failed to provide a DWC Form RFA or an objective PR-2 with a documented rationale for the necessity for a lift chair. Given the above, the request for purchase of lift chair for scooter is not medically necessary.

**MEDROX OINTMENT 120GM APPLIED UP TO TID PRN TO DECREASE PAIN:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105, 111, 28..

**Decision rationale:** California MTUS indicates that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety... are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Capsaicin: Recommended only as an option in injured workers who have not responded or are intolerant to other treatments. There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Additionally it indicates that Topical Salicylates are approved for chronic pain. According to the Medrox package insert, Medrox is a topical analgesic containing Menthol 5.00% and 0.0375% Capsaicin and it is indicated for the "temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness, and stiffness." Capsaicin is not approved and Medrox is being used for chronic pain, by the foregoing guidelines, the request for Medrox is not certified as medically necessary. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication since 2012. There was lack of documentation of objective functional benefit and an objective decrease in pain to support the necessity for ongoing treatment. Given the above, the request for Medrox ointment 120 g applied up to 3 times a day as needed to decrease pain is not medically necessary.

**NORCO 10/325MG ONE TAB TID PRN FOR PAIN:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60; 78.

**Decision rationale:** California MTUS Guidelines recommend opiates for chronic pain. There should be documentation of objective improvement, an objective decrease in pain, and documentation that the injured worker is being monitored for aberrant drug behavior and side effects. The cumulative dosing should not exceed 120 mg of oral morphine equivalence per day. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for greater than 1 year. There was lack of documentation of the above criteria. The request as submitted failed to indicate the quantity of medication being requested. Given the above, the request for Norco 10/325 mg 1 tab 3 times a day as needed for pain is not medically necessary.