

<b>Case Number:</b>	CM14-0147061		
<b>Date Assigned:</b>	09/15/2014	<b>Date of Injury:</b>	03/10/2007
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	08/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/10/2014

### 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 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:

Patient is a 41-year-old male who has submitted a claim for lumbar degenerative joint disease, partial laminectomy with fusion, right knee pain, left shoulder internal derangement, diabetic neuropathy, erectile dysfunction, GERD, and chronic gastritis associated with an industrial injury date 3/10/2007. Medical records from 2012 to 2014 were reviewed. Patient complained of chronic low back pain radiating to the bilateral lower extremities. Patient reported that current medications provided 50% pain relief and functional improvement with activities of daily living. Patient used ice packs at the lumbar area intermittently, which he found helpful. Patient used cane and knee braces for instability in his back and lower extremity weakness. He requested for a shoe orthotic to assist with foot arch pain. He likewise wanted an extended shoe horn to help get his shoes on and off, which he found difficult due to back immobility. Patient was unable to push heavy carts in the grocery; hence this request for utility shopping cart. Overall pain was rated 8/10 in severity, and relieved to 5/10 upon intake of medications. Physical examination of the lumbar spine showed muscles spasm, muscle rigidity, forward flexed posture and limited motion. Straight leg raise test was positive at the right. Sensation was diminished at the right lateral calf and bottom of foot. Gait was antalgic. Deep tendon reflexes were graded 1+ at lower extremities. Crepitus was noted at both knees, with full range of motion. Stability test revealed valgus laxity bilaterally. Shoulder range of motion was likewise restricted, with positive impingement test. Treatment to date has included lumbar surgery, physical therapy, use of ice gel pack, and medications such as Oxycodone, Morphine (since August 2014), Naprosyn, Flexeril (since 2013), Lidoderm patches, Nexium, and Mylanta (since 2013 to offset dyspepsia side effects from medication intake). Utilization review from 8/26/2014 denied the request for Mylanta #1 Bottle because the guideline did not recommend antacids for the treatment of dyspepsia; denied Flexeril 10 mg because long-term use was not recommended; denied Shoe

Orthotic Arch Supports and 1 External Show Horn because there was no diagnosis of knee osteoarthritis to support its use and there was no literature to support prescription of external shoe horn to assist the patient in taking on and off his shoes; denied Utility Shopping Cart because there was no literature to support its use for patients with chronic low back pain; denied Morphine 15 mg #60 because of no significant pain relief and functional improvement from medications; and denied Unknown Ice Gel Packs due to a lack of any clear indication for its use.

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

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

**Mylanta #1 Bottle:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: US Food and Drug Administration (Mylanta)

**Decision rationale:** The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the US Food and Drug Administration was used instead. Mylanta is used to treat acid indigestion, heartburn, gas, and sour stomach. It works by neutralizing acid in the stomach. It also causes the gas produced by some foods to remain dissolved. Patient is a diagnosed case of gastroesophageal reflux disease and chronic gastritis. Patient has been prescribed Mylanta since 2013. However, response to therapy is not documented. Moreover, patient is likewise on Nexium and there is no clear discussion as to why adjuvant therapy with Mylanta is necessary in this case. The medical necessity cannot be established due to insufficient information. Therefore, the request for Mylanta #1 bottle is not medically necessary.

**Flexeril 10mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Page(s): 41-42.

**Decision rationale:** According to page 41-42 of the CA MTUS Chronic Pain Medical Treatment Guidelines, sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In this case, the patient has been on Flexeril since 2013. Patient reported 50% pain relief and functional improvement from medication use. The most recent progress report showed evidence of muscle spasm, however, long-term use of muscle relaxant was not recommended. There was no discussion concerning need for variance from the guidelines. The request likewise failed to

specify quantity to be dispensed. Therefore, the request for Flexeril 10 mg was not medically necessary.

**Shoe Orthotic Arch Supports and 1 External Shoe Horn: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 371. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Section, Durable Medical Equipment (DME); Ankle and Foot Section, Orthotic Devices

**Decision rationale:** As stated on page 371 of the ACOEM Practice Guidelines, 2nd Edition (2004) referenced by CA MTUS, rigid orthotics may reduce pain experienced during walking and may reduce more global measures of pain and disability for patients with plantar fasciitis and metatarsalgia. ODG further states that orthotic devices are recommended for plantar fasciitis and for foot pain in rheumatoid arthritis. Both prefabricated and custom orthotic devices are recommended for plantar heel pain (plantar fasciitis, plantar fasciosis, heel spur syndrome). On the other hand, ODG states that durable medical equipment (DME) is defined as a device that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. In this case, patient requested for a shoe orthotic to assist with foot arch pain. He likewise wanted an extended shoe horn to help get his shoes on and off, which he found difficult due to back immobility. However, there was no comprehensive physical examination of the feet to support the request. Moreover, an extended shoe horn did not meet guideline criteria for durable medical equipment. It was still considered useful to a person even in the absence of a medical condition. It was likewise not primarily considered useful for medical purpose only. There was no discussion concerning need for variance from the guidelines. Therefore, the request for Shoe Orthotic Arch Supports and 1 External Shoe Horn was not medically necessary.

**Utility Shopping Cart: 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 Section, Durable medical equipment (DME)

**Decision rationale:** The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Knee Section was used instead. It states that durable medical equipment (DME) is defined as a device that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's

home. DME includes bathroom and toilet supplies, assistive devices, TENS unit, home exercise kits, cryotherapy, orthoses, cold/heat packs, etc. In this case, patient is unable to push heavy carts in the grocery; hence this request for utility shopping cart. However, it does not meet guideline criteria for durable medical equipment. A shopping cart is still useful to a person even in the absence of a medical condition, and it is not appropriate for use in a patient's home. It is likewise not primarily considered useful for medical purpose only. There is no discussion concerning need for variance from the guidelines. Therefore, the request for utility shopping cart is not medically necessary.

**Morphine 15mg #60:** 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 Opioids, Page(s): 78.

**Decision rationale:** As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on morphine since 08/05/2014, as adjuvant therapy with Oxycodone. Patient reported that current medications provide 50% pain relief and functional improvement with activities of daily living. However, there is no discussion concerning presence or absence of opioid side effects. There is likewise no urine drug screen result submitted for review to monitor drug compliance. Guideline criteria are not met. MTUS Guidelines require clear and concise documentation for ongoing management. There is likewise no discussion as to why strong opioid analgesics should be added in this case. Therefore, the request for Morphine 15 mg, #60 is not medically necessary.

**Unknown Ice Gel Packs:** 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), Pain Section, Hot/Cold Packs

**Decision rationale:** The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG) was used instead. ODG states that hot / cold packs are recommended as an option for acute pain. At-home local application of cold packs in first few days of acute complaint is recommended; thereafter, applications of heat packs or cold packs. The evidence for the application of cold treatment to low-back pain is more

limited than heat therapy. 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. In this case, patient complains of chronic low back pain radiating to the bilateral lower extremities. Patient uses ice packs at the lumbar area intermittently, which he has found helpful. It is unclear why a new set of ice packs is being requested at this time. The medical necessity cannot be established due to insufficient information. There is no evidence that current cold pack is not functioning. Therefore, the request for unknown ice gel packs is not medically necessary.