MAXIMUS Federal Services

Case Number:	CM14-0172466		
Date Assigned:	10/23/2014	Date of Injury:	11/08/1999
Decision Date:	12/02/2014	UR Denial Date:	09/23/2014
Priority:	Standard	Application Received:	10/17/2014

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 Family Medicine 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:

This 65-year old man apparently sustained injuries to his back and lower extremities as a result of sliding down a mountain. He also apparently has had multiple subsequent injuries. There is no clear description of the injury or injuries in the available records. Date of injury is 11/8/99. Past medical history is significant for hypertension, smoking and asthma. His current primary provider, a physiatrist, lists problems which include back pain with bilateral sciatica, neuralgia/neuritis, knee pain, myofascial pain syndrome/fibromyalgia, generalized anxiety, testicular hypofunction, ankle pain and ulcers of the both feet. There are nine progress notes from the primary treater's office in the available records, ranging from 1/6/14 to 8/26/14. All document that the patient complains of back and lower extremity pain. All document that the patient is well developed and well nourished. None of them document any upper extremity exam except for the 1/6/14 note, which documents normal strength and range of motion of the upper extremities. The patient apparently has an ulcer or ulcers of his feet or ankles which are so inadequately described that it is impossible to determine where they are, how large they are, or how long they have been present. At first, the notes describe a "pressure sore" of the right foot, which is improving. Exam findings are either not documented, or documented as "presence of scar". The 5/21/14, note states the patient has a healing wound of the right foot and a new left foot wound, neither of which are described. The 6/13/14 note states that the right foot wound has been present for several years and is not healing. It does not mention the left foot wound. The 7/31/14 note states that the patient continues to have 2 open wounds on each foot, and describes 2 ulcerations of both left and right medial malleoli (inner ankle), without further documentation. The 8/26/14 describes a large, new odiferous ulcer of the left foot, and a healing ulcer of the right foot. All of the notes document that the patient is permanently disabled and off work. Otherwise the patient's functional status is documented in a very confusing fashion. He

can drive and walk, but has walked with a cane beginning 5/21/14. He is variously described as being able to do all activities of daily living including house and yard work, and as being able to perform self-care only. There is no clear progression toward either decreasing or increasing function. At some visits, functional status is not described at all. Documented ongoing medications include Cymbalta, Abilify, Nuvigil, pentoxifylline ER, Zanaflex, Norco 10/325, and Oxycontin 80 mg. Testosterone 200 mg IM is administered periodically. Keflex was prescribed on 1/6/14, and again on 8/26/14. The 8/26/14 note contains a new complaint of shoulder pain from walking with a cane. Exam findings include tenderness, swelling, deformities and decreased range of motion of the feet and ankles with a large ulcer at the left medial foot and ankle, and a scar of the right ankle. No exam of the shoulders was performed. Diagnoses included ankle pain, degenerative joint disease, and ulcer of heel and midfoot. The plan included referral to a podiatrist, a request for a motorized wheelchair to allow the patient to be non-weight bearing on both ankles. It notes that the patient can't push a wheelchair due to shoulder pain. There is a request for a referral to a surgeon or wound clinic for "evaluation and possible surgeon". The patient was given prescriptions for Cymbalta, Keflex, Norco 10/325, Abilify and Zanaflex. The motorized wheelchair, the referral to wound care for evaluation treatment, the Norco and the Zanaflex were denied in the Utilization Review (UR) on 9/23/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized wheelchair: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Power mobility devices (PMDs) (see Knee Chapter)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), both knee and ankle chapter, power motility devices Other Medical Treatment Guideline or Medical Evidence: UptoDate, an online, evidence-based review service for clinicians (www.uptodate.com), Clinical assessment of wounds, Basic principles of wound management, Medical management of lower extremity chronic venous disease.

Decision rationale: The ODG guideline cited above states that power motility devices are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, if the patient has sufficient upper extremity function to propel a manual wheelchair, or if there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care.The UptoDate references state that the evaluation of any wound should include a careful history including onset and perceived causal factors of the wound, how painful the would is, and documentation of risk factors for non-healing. Location and number of wounds should be documented, as well as the width, length and depth of each wound. The presence of undermining, of cellulitis, and drainage should be documented. If there is a chronic ulcer, it is important to differentiate what caused it. The most

common causes of chronic ulcers include pressure from chronic compression of tissue over bony prominences in immobilized patients, ischemia, venous stasis, diabetic neuropathy, and malignancy. Treatment for ischemic ulcerations involves the performance of revascularization therapy as soon as possible. Treatment for venous stasis ulcers may include exercise such as ankle flexion and walking. The clinical documentation in this case does not support the provision of a motorized wheelchair. In the first place, it is not possible to determine what sort of ulcer or ulcers this patient has, and whether or not the optimal treatment would include avoiding weight bearing. This patient has risk factors for peripheral vascular disease, and does not have diabetes. Although he has been diagnosed as having pressure ulcers, he is not bedridden and does not appear to be at risk for developing pressure ulcers. The most likely etiologies in his case appear to be either ischemia or venous insufficiency. The recommended treatment does not include complete immobilization of the lower extremities for either of these diagnoses. The treatment for ischemic ulcers is prompt revascularization therapy, and the treatment for venous ulcers may actually include walking. The patient appears to be able to walk with a cane, and there is no documentation that a walker has been tried. If he does in fact require a wheelchair, there is no documentation that the patient has insufficient strength to propel a wheelchair, or that there is no available caretaker who might propel it for him. Based on the evidence-based citations above and on the clinical documentation provided for my review, a motorized wheelchair is not medically necessary. It is not medically necessary because it is not established that the patient should not or cannot walk. In addition, it is not medically necessary because even if a wheelchair were dispensed, there is no documentation that the patient does not have the upper extremity strength to propel it, and that he does not have a caretaker who could propel it for him.

Wound care evaluation and treatment: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines: Ankle & Foot, office visits

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: X UptoDate, an online, evidence-based review service for clinicians (www.uptodate.com), Clinical assessment of wounds, Basic principles of wound management, Medical management of lower extremity chronic venous disease.

Decision rationale: The UptoDate references state that the evaluation of any wound should include a careful history including onset and perceived causal factors of the wound, how painful the would is, and documentation of risk factors for non-healing. Location and number of wounds should be documented, as well as the width, length and depth of each wound. The presence of undermining, of cellulitis, and drainage should be documented. If there is a chronic ulcer, it is important to differentiate what caused it. The most common causes of chronic ulcers include pressure from chronic compression of tissue over bony prominences in immobilized patients, ischemia, venous stasis, diabetic neuropathy, and malignancy. For optimal wound healing, the wound bed needs to be well vascularized, free of devitalized tissue, clear of infection, and moist. Wound dressings should be chosen based on their ability to manage dead space, control exudate, reduce pain during dressing changes, prevent bacterial overgrowth, and

ensure proper fluid balance. If debridement is needed, sharp surgical debridement should be performed. Deep wounds may require negative pressure wound therapy. Treatment for ischemic ulcerations involves the performance of revascularization therapy as soon as possible. Treatment for venous stasis ulcers may include exercise such as ankle flexion and walking. Although the clinical documentation in this case is abysmal, it does support the referral of this patient to a wound care clinic. It is not clear how many chronic ulcers this patient has, where they are located, or what caused them. However, it does seem quite clear that he has had at least one ulcer for at least 11 months, and that the size or number of his ulcer or ulcers is increasing. None of the recommended evaluation or treatment for chronic ulcers has occurred. It is not even clear that dressings for the ulcers are being provided. Apparently part of the rationale for following this patient for so long and for doing so little is that he was previously referred to a would clinic and did not like the treatment he received there, possibly because he appropriately received sharp debridement. Based on the evidence-based citations above and on the clinical documentation provided for my review, a referral to a wound care clinic for evaluation and treatment IS medically necessary because the current treating physician has not made an appropriate evaluation of or provided any appropriate treatment for this patient's chronic lower limb ulcer or ulcers.

Norco 10/325mg #240 x 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug listOn-Going ManagementWeaning of Medic.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain; Criteria for use of Opioids; Opioids for neuropathic pain; Opioid.

Decision rationale: According to the first guideline cited above, medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. The remaining guidelines state that opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine in the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Specific goals should be set, and continued use of opioids should be contingent on meeting these goals. Opioids should be discontinued if there is no improvement in function or if there is a decrease in function. Opioids are not recommended as first-line therapy for neuropathic pain. The response of neuropathic pain to drugs may depend on the cause of the pain. There are very limited numbers of studies that involve opioid treatment for chronic lumbar root pain. A recent study found that chronic radicular lumbar pain did not respond to opioids in doses that have been effective for painful diabetic neuropathy and postherpetic neuralgia. Opioid dosing should not exceed 120 oral morphine equivalents per day. Patients taking opioids sometimes develop abnormal pain, a change in pain pattern, or persistence in pain at higher levels than expected, which are actually a result of taking opioids. This is called opioid hyperalgesia. Opioid hyperalgesia should be screened for, as it actually may require weaning off opioids rather than increasing doses.The clinical findings in this case do not support the continued use of Norco. There is no evidence of any evaluation to determine if the patient's pain is nociceptive or neuropathic. No assessment for

risk factors for abuse appears to have occurred. This patient has at least one obvious risk factor: continuing to smoke despite diagnoses of asthma and high blood pressure. It may have been inappropriate to prescribe any potentially addictive medications to this patient in the first place. The patient's current (and long-term) dose of Norco is 2 4x/day, which results in a total dose of 80 mg of hydrocodone per day. In addition to the 80 mg of Oxycontin which he takes daily, this means he is taking 280 mg oral morphine equivalents per day. This is well above the recommended maximum dosage of 120 equivalents per day. This amount of opioid may be causing side effects such as dizziness and drowsiness, which contribute to the patient's failure to make any functional recovery and may also be making it difficult for him to walk. There is no evidence that any functional goals were set or are being monitored as a condition of continued Norco use. The patient totally disabled, which would imply that no substantial functional recovery has occurred. Based on the evidence-based guidelines cited above, and the clinical documentation provided for my review, Norco 10/325 #240 with one refill is not medically necessary for this patient. Norco 10/325 is not medically necessary because of the lack of appropriate documentation of the patient's status prior to beginning it, because of the failure to set and monitor functional goals, because the patient's daily opioid dosage exceeds that which is recommended, because of the failure to evaluate for opioid hyperalgesia, and because of the failure to discontinue Norco when it became clear that it has not produced any functional recovery.

Zanaflex 4mg #180 x 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63; 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, Muscle relaxants Page(s): 60; 63-66.

Decision rationale: Zanaflex is brand-name Tizanidine, which is a centrally-acting muscle relaxant. Per the first reference cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it.Per the second reference, non-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 most low back pain patients, they show no benefit. There is no additional benefit if they are used in combination with NSAIDs. Efficacy appears to diminish over time. Tizanidine is a centrally acting antispasmodic drug. Its side effects include somnolence, dizziness and dry mouth.The clinical documentation does not support the use of Zanaflex in this case. It has been in use for at least 11 months, and is sedating. It has not produced any functional improvement in this patient. In combination with the very heavy doses of opioids the patient is taking, it may actually be contributing to the patient's inability to walk.Based on the MTUS citations above and on the clinical records provided for my review, Zanaflex 4 mg #180 with one refill is not medically necessary. It is not medically necessary because it is centrally acting and therefore not recommended, because it has been provided for a far longer period that the short-term use recommended for muscle relaxants, and because it has produced no functional recovery in this patient and may actually be contributing to his disability.