

Case Number:	CM13-0006362		
Date Assigned:	08/26/2013	Date of Injury:	11/01/2006
Decision Date:	01/02/2014	UR Denial Date:	07/10/2013
Priority:	Standard	Application Received:	08/02/2013

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 Internal Medicine and Pulmonary Diseases 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.

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 47-year-old female who reported an injury on 11/01/2006. The mechanism of injury involved a fall. The most recent diagnoses include possible lumbar radiculopathy, status post operative arthroscopy of the right knee, and torn meniscus and/or internal derangement of the left knee. Physical examination revealed tenderness to palpation of the cervical spine with guarding and moderate restriction of voluntary range of motion, negative compression testing, tenderness to the left lower lumbar paraspinal musculature with mild guarding, significant loss of range of motion voluntarily, moderate restriction of straight leg raising bilaterally, slight crepitation of the left knee with restricted range of motion, slight crepitation of the right knee, and normal gait. X-rays obtained in the office on that date of bilateral knees indicated early osteoarthritic changes involving all 3 compartments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 250 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66, 124.

Decision rationale: The MTUS Chronic Pain Guidelines indicate that muscle relaxants are recommended as non-sedating second-line options for short-term treatment of acute

exacerbations in individuals with chronic low back pain. However, in most lower back pain cases, they show no benefit beyond nonsteroidal anti-inflammatory drugs (NSAIDs) in pain and overall improvement. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Soma is not recommended for longer than a 2 to 3 week period. Tapering should be individualized for each individual. As per the latest physical examination, there were no palpable muscle spasms documented. There has not been mention of functional gain attributed to Soma that defines the need for the ongoing use. The request cannot be supported when there has not been defined evidence of the need for finding of muscle tightness or spasms and absence of specific evidence of functional gain resulting from the medication. The request for Soma 250 mg is not medically necessary and appropriate.

Xanax 0.5 mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

Decision rationale: The MTUS Chronic Pain Guidelines indicate that benzodiazepines are not recommended for long term use, because long term efficacy is unproven and there is a risk of dependence. Most guidelines limit the use to 4 weeks. Tolerance to hypnotic effects and anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. As per the clinical notes submitted for review, it was documented that the Xanax prescription was issued for insomnia. There is no comment of use or effect of use nor functional benefit of Xanax. There is also no mention of using insomniac medications. As guidelines do not recommend benzodiazepines for long term use, continuation of this medication cannot be determined as medically appropriate. There has not been defined need for ongoing use of a benzodiazepine. The request for Xanax 0.5 mg #30 is not medically necessary and appropriate.

Gaviscon: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 115. Decision based on Non-MTUS Citation Physician's Desk Reference (PDR), 2013.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: The MTUS Chronic Pain Guidelines indicate that determination should be made if an individual is at risk for gastrointestinal events. Gaviscon is a non-prescription medication for the treatment of heartburn and gastroesophageal reflux disease. According to the clinical notes submitted for review, there is no comment by the primary treating physician that relates the need for Gaviscon for treating gastric symptoms associated with the medications used in treating this industrial injury. The employee has not been prescribed a nonsteroidal anti-inflammatory medication or any other medication that is causing gastrointestinal (GI) symptoms

or the need for Gaviscon. There also has not been any comment or mention of altered diet or changes made to deal with GI symptoms related to the industrial injury. The request for Gaviscon is not medically necessary and appropriate.

Capsaicin Gel 60 gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: The MTUS Chronic Pain Guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Capsaicin is recommended only as an option in individuals who have not responded or are intolerant to other treatments. It is indicated for osteoarthritis, fibromyalgia, and chronic nonspecific back pain. There is no mention within the medical record that the employee has received a conventional medication and treatment for the low back and knee pain that was not well-tolerated. There is only comment that the capsaicin is being used for pain. The request for Capsaicin Gel 60 gm is not medically necessary and appropriate.

Omeprazole: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: The MTUS Chronic Pain Guidelines indicate that individuals with no risk factor and no cardiovascular disease do not require a proton pump inhibitor. Proton pump inhibitor is recommended for individuals at intermediate or high risk for developing gastrointestinal (GI) events. In the clinical documentation submitted for review, there is no comment by the treating physician that relates the need for the proton pump inhibitor for treating gastric symptoms associated with the medications used in treating this employee. The employee has not been prescribed a nonsteroidal anti-inflammatory drug (NSAID) medication. There is no reference to other prescribed medications causing GI symptoms to require the need for omeprazole. Furthermore, there is no indication as to why this employee would not benefit from an over-the-counter product, as opposed to a prescription medication. The request for Omeprazole 20 mg #60 is not medically necessary and appropriate.

IF Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

Decision rationale: The MTUS Chronic Pain Guidelines indicate that interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Pain should be ineffectively controlled due to diminished effectiveness of medications or side effects. Individuals should also prove unresponsive to conservative measures. As per the clinical notes submitted for review, the employee has utilized an interferential unit for pain relief. There has not been any indication of functional gain attributed to the use of the interferential unit, including no presenting evidence that medication has been reduced. The request for IF Unit is not medically necessary and appropriate.

Commode chair: 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), Knee & Leg Chapter, Online Edition.

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, Online Edition.

Decision rationale: The Official Disability Guidelines indicate that durable medical equipment is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. Most bathroom and toilet supplies do not customarily serve a medical purpose and are primarily used of convenience in the home. Certain DME toilet items, including commodes, are medically necessary if the individual is bed or room confined, and devices such as raised toilet seats, commode chairs, sitz baths and portable whirlpools may be medically necessary when prescribed as part of a medical treatment plan for injury, infection, or conditions that result in physical limitations. According to the clinical notes submitted for review, there is insufficient information provided by the attending healthcare provider to associate or establish the medical necessity or rationale for the requested commode chair. Bedside commodes are considered a comfort of convenience item, hygienic equipment, and are not primarily medical in nature. The request for commode chair is not medically necessary and appropriate.