

<b>Case Number:</b>	CM14-0109313		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	07/19/2000
<b>Decision Date:</b>	10/03/2014	<b>UR Denial Date:</b>	07/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2014

### 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, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 53-year-old female who reported an injury on 07/19/2000. The mechanism of injury was not provided. Her diagnoses were noted to be lumbago, and low back pain. Prior treatments included medications and durable medical equipment. Diagnostic studies included an unofficial MRI of the lumbar spine performed 01/07/2011 that was noted to show findings of spondylosis and foraminal narrowing at left L3-4 and bilateral L4-S1. Surgical history was not provided. Within a clinical evaluation dated 06/03/2014 the injured worker had subjective complaints of low back pain. The physical exam findings revealed atrophy in the lower extremities and tenderness over the lumbar spine at facet joint, with decreased flexion, extension and lateral bending. Her medications were noted to be Methadone, Neurontin, Norco, Xanax, and Roxicodone. The treatment plan was to continue with medications. In addition, it was recommended that the injured worker have a motorized scooter. The rationale for the request was that the injured worker's current scooter was broken and could not be fixed due to age. The Request for Authorization form was submitted on 06/30/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Motorized Scooter:** Upheld

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

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

**Decision rationale:** The request for 1 Motorized Scooter is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines do not recommend a power mobility device 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 medical records provided indicate the injured worker's previous motorized scooter was broken and could not be fixed due to age. It was noted she needed it to negotiate long distances. There is a lack of documentation indicating the injured worker could not propel a manual wheelchair. She was noted to have full strength and tone in the bilateral upper extremities. There is also no indication the injured worker did not have a caregiver who was available, willing, and able to provide assistance with a manual wheelchair. Furthermore, there is a lack of documentation regarding the state of the injured worker's current motorized scooter to verify it was malfunctioning and could not be repaired. Therefore, the request for a Motorized Scooter is not medically necessary.

**Methadone 10mg #360 With 1 Refill:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Methadone Page(s): 61-62.

**Decision rationale:** The request for Methadone 10mg #360 with 1 refill is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines recommend Methadone as a second line drug for moderate to severe pain if the potential benefits outweigh the risk. The FDA reported that they had received reports of severe morbidity or mortality with this medication. The medical records provided indicate an ongoing prescription for Methadone since July of 2012. A complete pain assessment was not provided. There is no indication of significant pain relief or objective functional improvements with the use of Methadone. The clinical documentation submitted fails to provide adequate monitoring for the dosing of Methadone. The submitted request fails to provide a frequency. Therefore, the request for Methadone 10mg #360 with 1 refill is not medically necessary.

**Xanax 0.5mg #120 With 1 Refill:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (chronic)

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

**Decision rationale:** The request for Xanax 0.5mg #120 with 1 refill is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines do not recommend benzodiazepines for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. The medical records provided indicate an ongoing prescription for Xanax since at least November of 2012. There is no indication of improved pain or function with the use of Xanax. Nonetheless, the guidelines do not recommend long-term use of benzodiazepines. Therefore, continued use is not supported. As such, the request for Xanax 0.5mg #120 with 1 refill is not medically necessary.