

<b>Case Number:</b>	CM14-0193819		
<b>Date Assigned:</b>	12/03/2014	<b>Date of Injury:</b>	08/07/2010
<b>Decision Date:</b>	01/14/2015	<b>UR Denial Date:</b>	11/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/19/2014

### 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 Occupational 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 individual is a 40 y/o male who developed chronic low back pain subsequent to a strain injury on 8/7/10. He has been clinically diagnosed with a right-sided radiculopathy. MRI studies show neuroforaminal narrowing at the L5-S1 level and Electrodiagnostic studies are consistent with an L5 radiculopathy. Surgery is being considered. He is currently treated with Tramadol, Xanax, Flexeril, compounded topicals, and Prilosec for a medically confirmed gastritis. He has had multiple drug screens (5/6/14, 9/2/14, and 11/11/14) none of which are positive for illegal drug use. No aberrant drug related behaviors are documented. No trial period or benefits from electrical stimulation are reported.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Topical cream:** 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 Topical Analgesics Page(s): 111-113.

**Decision rationale:** MTUS Guidelines are very specific that if a topical ingredient is not Guideline recommended, a compound with this ingredient is not recommended. Although the

topical cream is not stated, the records suggest the compound appears to include topical Ketoprofen, Gabapentin and Cyclobenzaprine, all 3 of which are specifically not recommended by Guidelines. The topical cream is not consistent with Guidelines and is not medically necessary.

**Xanax:** 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 Benzodiazepines Page(s): 24.

**Decision rationale:** MTUS Guidelines do not support the long-term use of Benzodiazepines for chronic pain or anxiety problems. Recommended use is limited to 4 weeks. There are no unusual circumstances to justify an exception to Guidelines. The Xanax is not medically necessary.

**Flexeril:** 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 Muscle Relaxants Page(s): 64.

**Decision rationale:** MTUS Guidelines do not recommend the long-term daily use of muscle relaxants. Recommended use is limited to short term during flare-ups. There are no unusual circumstances to justify a chronic long-term use of Flexeril. The Flexeril is not medically necessary.

**Urine toxicology:** 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): 78-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Urine Drug Screening

**Decision rationale:** MTUS Guidelines recommend drug screening if long-term opioids are utilized, however the MTUS Guidelines do not provide details regarding what is considered a reasonable frequency of screening. ODG Guideline provides guidance on this issue and recommends frequency based on risk factors. This individual appears to be at low risk for misuse for which Guidelines recommend annual screening as adequate. At this time, the request for repeat drug screening is not medically necessary.

**X-force with solar care:** 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 Transcutaneous electrotherapy Page(s): 114-116.

**Decision rationale:** The X-Force device with Solar Care is an TENS electrostimulation device with heating unit that is manufactured by SevenSeas. Guidelines are very specific regarding electrostimulation devices. If a TENS unit is considered, there is not support for combining the unit with other functions. In addition, a unit is to be trialed for 30 days of home use with benefits clearly documented, before longer term use and purchase is recommended. Guidelines do not support this combination device, plus the necessary preliminary trial and benefit assessment is not reported. The X-Force with solar care is not supported by Guidelines and is not medically necessary.

**Prilosec:** Overturned

**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 NSAIDs and GI symptoms Page(s): 68.

**Decision rationale:** MTUS Guidelines support use of Proton Pump Inhibitors if there is GI distress associated with medication use or there is a diagnosis of gastritis. A GI specialist has confirmed a diagnosis of gastritis. The use of Prilosec is medically necessary in these circumstances.