

<b>Case Number:</b>	CM15-0146257		
<b>Date Assigned:</b>	08/07/2015	<b>Date of Injury:</b>	02/08/2012
<b>Decision Date:</b>	09/09/2015	<b>UR Denial Date:</b>	07/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/28/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Texas, California  
 Certification(s)/Specialty: Family Practice

### 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 57-year-old male who sustained a work related injury February 8, 2012. Past history included C5-C6 fusion. A treating physician's notes, dated January 20, 2015, documented the injured worker has a history of right knee chondromalacia, diminutive medial meniscus and has already underwent osteotomy procedure for the knee, but he also has no ACL. According to a treating physician's notes dated June 25, 2015, the injured worker presented status post right knee ACL (anterior cruciate ligament) reconstruction, medial meniscus transplant April 24, 2015. He started full weight bearing last month and is currently in physical therapy. Medication included ibuprofen, Valium, Ambien and Percocet. Physical examination revealed extension 0 degrees, knee flexion 150 degrees, no tenderness to palpation, moderate effusion and negative Lachman. Assessment is documented as status post right knee ACL reconstruction, medial meniscus transplant. Treatment plan included continue with therapy a large garment "Kneehab device" to help facilitate quad strength. At issue, is the request for authorization for Valium and a Kneehab device. The past medical history includes Anxiety, insomnia. A recent detailed psychological evaluation note of the psychiatrist was not specified in the records provided. The patient had received an unspecified number of PT visits for this injury. Per the note dated 5/28/2015 the physical examination of the right knee revealed 4+ strength, muscle atrophy. Physical examination of the right knee revealed 150-degree flexion, moderate effusion, no tenderness on palpation and negative Lachman sign.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Valium 5mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines - Benzodiazepines page 24 Official Disability Guidelines, current online version. Pain (updated 07/15/15) Benzodiazepines.

**Decision rationale:** Request: Valium 5mg #60 According to MTUS guidelines, Benzodiazepines are "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of actions includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety." Per the cited guidelines: "Benzodiazepines are a major cause of overdose, particularly as they act synergistically with other drugs such as opioids (mixed overdoses are often a cause of fatalities)." Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. Tolerance to lethal effects does not occur and a maintenance dose may approach a lethal dose as the therapeutic index increases. The best prevention for substance use disorders due to benzodiazepines is careful prescribing. (Baillargeon, 2003) (Ashton, 2005) (Dickinson, 2009) (Lader, 2009) Adults who use hypnotics, including benzodiazepine, have a greater than 3-fold increased risk for early death, according to results of a large matched cohort survival analysis. The risks associated with hypnotics outweigh any benefits of hypnotics, according to the authors. In 2010, hypnotics may have been associated with 320,000 to 507,000 excess deaths in the U.S. alone. "The AGS updated Beers criteria for inappropriate medication use includes benzodiazepines. (AGS, 2012) Use of benzodiazepines to treat insomnia or anxiety may increase the risk for Alzheimer's disease (AD)". A recent detailed psychological evaluation note of the psychiatrist was not specified in the records provided. Any trial of other measures for treatment of insomnia is not specified in the records provided. As mentioned above, prolonged use of anxiolytic may lead to dependence and does not alter stressors or the individual's coping mechanisms. The cited guideline recommends that if anti-anxiety medication is needed for a longer time, appropriate referral needs to be considered. The medical necessity of the request for Valium 5mg #60 is not medically necessary in this patient given the records provided and the guidelines cited. When discontinuing a benzodiazepine, it is recommended that it should be tapered over time according to the discretion of the treating provider to prevent withdrawal symptoms.

**Kneehab X 1:** 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 and leg chapter, walking aids (braces, canes, crutches, orthoses and walkers).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) page 121 Neuromuscular electrical stimulation (NMES devices). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (updated 07/10/15) NMES devices.

**Decision rationale:** Kneehab X 1: Kneehab is a device that delivers electrical stimulation in the form of NMES or TENS to the knee. Per the CA MTUS Chronic Pain Medical Treatment Guidelines, neuromuscular electrical stimulation (NMES devices) is "Not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain. (Moore 1997). NMES devices are used to prevent or retard disuse atrophy, relax muscle spasm, increase blood circulation, maintain or increase range-of-motion, and re-educate muscles." Per the cited guidelines, NMES devices are, "Recommended as an option only for short-term use during rehabilitation early in the postoperative period following major knee surgeries. Fourteen randomized controlled trials have evaluated the use of electrical stimulation during the course of postoperative ACL reconstruction rehabilitation. It appears that for neuromuscular electrical stimulation to be successful, it must be applied in a high-intensity setting early in the postoperative period. High-intensity stimulation typically is administered in an outpatient physical therapy setting, thus precluding home units. Neuromuscular electrical stimulation may help achieve improved quadriceps strength but does not appear to be a requirement for successful ACL reconstruction rehabilitation." The cited guidelines do not recommend home units of NMES. The patient had received an unspecified number of PT visits for this injury. Previous conservative therapy notes were not specified in the records provided. The outcome of quadriceps strengthening exercises on the muscle weakness and atrophy, during PT and as a voluntary home exercise program is not specified in the records provided. The medical necessity of the request for Kneehab X 1 is not medically necessary for this patient.