

<b>Case Number:</b>	CM14-0000027		
<b>Date Assigned:</b>	05/14/2014	<b>Date of Injury:</b>	04/23/1995
<b>Decision Date:</b>	07/10/2014	<b>UR Denial Date:</b>	12/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/31/2013

### 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 Anesthesiology has a subspecialty in Pain Management 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:

The patient is a 53-year-old female who has submitted a claim for thoracic disc degenerative disease, cervical disc degenerative disease, generalized anxiety disorder, lumbago and lumbosacral neuritis associated with an industrial injury date of April 23, 1995. Medical records from 2013-2014 were reviewed, the latest of which dated March 10, 2014 revealed that the patient presents with flare up of low back and right hip pain graded 10/10. On physical examination, there is noted swelling and spasm. There is positive straight leg raising test bilaterally at 10 degrees sitting. On physical examination done last January 15, 2014, there is reduced sensation in the L5-S1 distribution bilaterally. There is positive straight leg raising test bilaterally at 20 degrees sitting. There is limitation in range of motion of the lumbar spine with flexion to approximately 10 degrees, extension to approximately 10 degrees, right bending to approximately 20 degrees, left bending to approximately 30 degrees, right rotation to approximately 20 degrees, and left rotation to approximately 20 degrees. Treatment to date has included fusion at L4-5 with internal fixation, bilateral hardware blocks L5 (12/5/13), caudal epidural steroid injection (12/5/13), trigger point injections at bilateral lumbar paraspinous muscles (12/5/13), and medications which include Flexeril, lisinopril, Neurontin, buspirone, Ativan, tizanidine, Soma, oxycodone, Norco, Senokot, and trazodone.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**HYDROCO/APAP TAB 10/325 MG #90: 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 9792.24.2 Page(s): 78-81.

**Decision rationale:** According to pages 78-81 of the CA MTUS Chronic Pain Medical Treatment Guidelines, ongoing opioid treatment is not supported unless prescribed at the lowest possible dose and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In this case, the patient has been using hydrocodone/APAP since July 2013 for pain. The most recent clinical evaluation revealed no analgesia and functional improvement with its use. Also, there is no discussion regarding the side effects or possible aberrant behavior with opioid use. The medical necessity of hydrocodone/APAP was not established. Therefore, the request for Hydroco/APAP TAB 10/325mg #90 is not medically necessary.

**OXYCONTIN TAB 20MG #90:** 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 9792.24.2 Page(s): 78-81.

**Decision rationale:** According to pages 78-81 of the CA MTUS Chronic Pain Medical Treatment Guidelines, ongoing opioid treatment is not supported unless prescribed at the lowest possible dose and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In this case, the patient has been using oxycontin since July 2013 for pain. The most recent clinical evaluation revealed no analgesia and functional improvement with its use. Also, there is no discussion regarding the side effects or possible aberrant behavior with opioid use. The medical necessity of oxycontin was not established. Therefore, the request for Oxycontin Tab 20mg #90 is not medically necessary.

**ATAVAN 0.5MG #135:** 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 9792.24.2 Page(s): 24.

**Decision rationale:** According to page 24 of the CA MTUS Chronic Pain Medical Treatment 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 its use to 4 weeks. In this case, Ativan has been used since July 2013. The most recent clinical evaluation does not indicate relief of symptoms and functional improvement with benzodiazepine use. The continued use of

lorazepam has exceeded guideline recommendation. Therefore, the request for Ativan 0.5mg #135 is not medically necessary.