

<b>Case Number:</b>	CM14-0108032		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	02/19/1999
<b>Decision Date:</b>	11/26/2014	<b>UR Denial Date:</b>	06/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/11/2014

### 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 Iowa. 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 56 year-old female with a date of injury of 02/19/1999. A review of the medical documentation indicates that the patient is undergoing treatment for chronic low back pain. Subjective complaints (6/16/2014) include low back pain and numbness and pain going down her right lower extremity. Objective findings (6/16/2014) include low back tenderness and muscle spasm, significantly reduced lumbar range of motion, positive straight leg test on the right, weakness in the right lower extremity (ankle/foot), antalgic gait, and decreased sensation in the L4 nerve root. Diagnoses include chronic low back pain and lumbar discogenic disease L4-L5. The patient has undergone studies to include MRI (9/12/12), which showed L5-S1 disc desiccation and narrowing and L4-5 bulging disc. The patient has previously undergone chiropractic therapy, physical therapy, and multiple medication therapies. A utilization review dated 6/25/2014 did not certify the request for Tizanidine 4 mg #30 refill x4, soma 350 mg #30, Lorazepam #30 refill x4; and modified the request for Norco 10/325 #90 refill x4 to Norco 10/325 #90 no refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #90 RF x4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Page(s): 91.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Official Disability Guidelines (ODG) Neck and Upper Back (Acute and Chronic), Low Back - Lumbar & Thoracic (Acute & Chronic), Opioids, Pain

**Decision rationale:** According to MTUS guidelines, opioids are indicated mainly for osteoarthritis only after first-line conservative options have failed, and should include clear improvement in functional status for continued use. There is limited evidence to support long-term use for back or other musculoskeletal pain. MTUS also states that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur and an improved response to treatment should be observed. MTUS recommends discontinuing therapy if there is no improvement in pain or function. ODG does not recommend the use of opioids for low back pain except for short use for severe cases, not to exceed 2 weeks. The patient has exceeded this 2 week recommendation for treatment length, and appears to have been on this medication for an extended period of time. The most recent treating physician states they are intending to remove all other opioid therapy excepting the Fentanyl patch, which was approved for use. There is no prior documentation regarding the reported pain over time or specific improvement while on this medication. Prior documentation appears to show no improvement in patient status despite the long-term opioid treatment. Therefore, the request for Norco 10/325 #90 refill x4 is not medically necessary at this time.

**Tizanidine 4mg #30 RF x4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant Page(s): 64-66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Zanaflex Page(s): 29, 63-67.

**Decision rationale:** Tizanidine is classified as a muscle relaxant. According to MTUS chronic pain guidelines, muscle relaxants are only recommended for chronic back pain for short-term treatment of acute exacerbations. MTUS states that muscle relaxants may be effective in reducing pain and muscle tension, but in most back pain cases they show no benefit beyond NSAIDs in pain and functional improvement. The guidelines recommend against the long-term use of muscle relaxants. This class of drug also has some side effects, including possible mood effects such as euphoria, which could be potentially concerning in a patient with another mental health diagnosis. The patient appears to have been on this medication for an extended period of time, at least several months. The treating physician has not provided rationale for the extended use of this medication, and the medical documentation does not contain evidence of functional improvement or documented trials and failures of first line therapies. The only potential indication is the documentation of muscle spasms, but it is unclear if these are acute in nature or if the medication is helping with these symptoms since they are still occurring despite ongoing therapy. It is also unclear why the patient would require more than one muscle relaxant. Therefore, the request for Tizanidine 4 mg #30 refills x4 is not medically necessary.

**Soma 350mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) and Muscle relaxants for pain Page(s): 29, 63-67. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Soma Carisoprodol

**Decision rationale:** Soma (Carisoprodol) is classified as a muscle relaxant. According to MTUS chronic pain guidelines, muscle relaxants are only recommended for chronic back pain for short-term treatment of acute exacerbations. MTUS states that muscle relaxants may be effective in reducing pain and muscle tension, but in most back pain cases they show no benefit beyond NSAIDs in pain and functional improvement. ODG guidelines also indicate that soma is not recommended, as it is only intended for short-term relief as an adjunct to other therapies. All guidelines recommend against the long-term use of muscle relaxants. The patient appears to have been on this medication for an extended period of time, at least several months. The treating physician has not provided rationale for the extended use of this medication, and the medical documentation does not contain evidence of functional improvement or documented trials and failures of first line therapies. The only potential indication is the documentation of muscle spasms, but it is unclear if these are acute in nature or if the medication is helping with these symptoms since they are still occurring despite ongoing therapy. It is also unclear why the patient would require more than one muscle relaxant. Therefore, the request for Soma 350 mg #30 is not medically necessary.

**Lorazepam 1mg #30 Rfx4:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness, Benzodiazepines

**Decision rationale:** According to the MTUS guidelines, benzodiazepines (such as Ativan) are not recommended for long-term use for chronic pain because the long-term efficacy is unproven and there is a risk of dependence. Guidelines recommend limiting use to 4 weeks. Chronic benzodiazepines are the treatment of choice in very few conditions and tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. The treating physician did not provide adequate justification for use of benzodiazepines. The patient appears to have been on the medication for a long period of time, and there is no documented benefit to the medication, and the patient states they are having little to no improvement on their current treatment regimen. The documentation does not provide any extenuating circumstances for continuing the chronic use of benzodiazepines, or an alternative indication for use. Therefore, the request for Lorazepam 1 mg #30 refills x4 is not medically necessary.