

<b>Case Number:</b>	CM14-0016336		
<b>Date Assigned:</b>	04/11/2014	<b>Date of Injury:</b>	08/31/1990
<b>Decision Date:</b>	05/28/2014	<b>UR Denial Date:</b>	01/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2014

### 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 & Rehabilitation 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 63-year-old female who reported an injury on 08/31/1990 after a motor vehicle accident, which reportedly caused injury to multiple body parts. The injured worker developed chronic pain that was managed with multiple medications to include methadone, Alprazolam, and Tizanidine. The injured worker was evaluated on 11/13/2013. It was documented that she had pain controlled with current medications rated at a 3/10 with no evidence of abusive behaviors and consistent urine drug screens. Physical findings included limited range of motion of the lumbar spine secondary to pain and tenderness to palpation in the cervical and lumbar regions. The injured worker's diagnoses included pain in joint, shoulder region; pain in joint, lower leg; and low back pain. A Letter of Medical Necessity dated 12/11/2013 documented that the injured worker would continue medications to include methadone 10 mg and Verapamil 180 mg. It was documented that the injured worker's blood pressure was 146/84 with a pulse of 87. However, no other clinical findings for that date were provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ALPRAZOLAM 0.5MG:** Upheld

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

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

**Decision rationale:** The Expert Reviewer's decision rationale: The requested Alprazolam 0.5 MG is not medically necessary or appropriate. The California Medical Treatment and Utilization Schedule does not recommend the long-term use of benzodiazepines as there is a high risk of physical and psychological dependence. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 05/2013. Therefore, continued use would not be supported. Additionally, the request as it is submitted does not clearly identify a frequency or quantity. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Alprazolam 0.5 MG is not medically necessary or appropriate.

**METHADONE 10MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

**Decision rationale:** The Expert Reviewer's decision rationale: The requested Methadone 10 MG is not medically necessary or appropriate. The California Medical Treatment and Utilization Schedule recommends the continued use of opioids in the management of chronic pain be supported by a quantitative assessment of pain relief, documentation of functional benefit, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 05/2013. It is noted within the documentation that the injured worker is monitored for aberrant behavior with urine drug screens. However, there is no documentation of significant functional benefit or an adequate assessment of the injured worker's pain relief to determine the appropriateness of continued use of this medication. Additionally, the request does not include a frequency or quantity. Therefore, the appropriateness of this request cannot be determined. As such, the requested Methadone 10 MG is not medically necessary or appropriate.

**TIZANADINE 4MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

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

**Decision rationale:** The Expert Reviewer's decision rationale: The requested Tizanidine 4 MG is not medically necessary or appropriate. The California Medical Treatment and Utilization Schedule does support the short-term use of muscle relaxants for acute exacerbations of chronic

pain. Muscle relaxants are not recommended for long-term use. The clinical documentation submitted for review indicates that the injured worker has been on this medication since at least 05/2013. There are no exceptional factors noted within the documentation to extend treatment beyond Guideline recommendations. Therefore, continued use of this medication would not be supported. Additionally, the request as it is submitted does not clearly identify a quantity or frequency of treatment. Therefore, the appropriateness of the request cannot be determined. As such, the requested Tizanidine 4 MG is not medically necessary or appropriate.

**VERAPAMIL 180MG:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Citation:  
<http://www.nlm.nih.gov/medlineplus/druginfo/meds/a684030.html>  
<http://www.drugs.com/pro/verapamil.html>.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Diabetes Chapter, Hypertention Treatment.

**Decision rationale:** The Expert Reviewer's decision rationale: The requested Verapamil 180 MG is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this request. The Official Disability Guidelines recommend the use of medications in the management of hypertension. However, the clinical documentation does not provide any objective evidence to support the efficacy of this medication. Therefore, continued use would not be supported. Also, the request as it is submitted does not clearly identify a frequency or quantity. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Verapamil 180 MG is not medically necessary or appropriate.