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| Case Number: | CM14-0018596 | | |
| Date Assigned: | 04/18/2014 | Date of Injury: | 09/12/2002 |
| Decision Date: | 07/02/2014 | UR Denial Date: | 01/10/2014 |
| Priority: | Standard | Application Received: | 02/13/2014 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in Illinois. 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 Physician 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 76-year-old male who reported an injury on 09/12/2002. The mechanism of injury was not provided for review. The injured worker's chronic low back pain was managed with multiple medications and an intrathecal pain pump. The injured worker was evaluated on 12/30/2013. It was documented that the injured worker had 8/10 to 10/10 pain. The injured worker's medication included MS-Contin 30 mg, MiraLax 17 grams per dose, senna 8.6 mg, Skelaxin 800 mg, trazodone 100 mg, Dilaudid 4 mg and Valium 10 mg. Physical findings included limited lumbar range of motion secondary to pain and tenderness to palpation of the lumbar facets bilaterally from the L3-S1 levels. The injured worker had decreased motor strength in the left lower extremity and absent deep tendon reflexes in the left lower extremity. The injured worker's diagnoses included radiculopathy, pain, lumbar spine back pain, and failed back syndrome of the lumbar spine. The injured worker's treatment plan included continuation of medications and activity as tolerated.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF VALIUM 10MG, #60 WITH 1 REFILL: 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(s): 24.

Decision rationale: The requested prescription of Valium 10 mg #60 with 1 refill is not medically necessary or appropriate. The California Medical Treatment 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 does indicate that the injured worker has been on this medication since at least 10/2012. As the injured worker has been on this medication for an extended duration of time, continued use would not be supported. Additionally, as it is submitted, the request does not identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested prescription of Valium 10 mg #60 with 1 refill is not medically necessary or appropriate.

PRESCRIPTION OF SKELAXIN 800MG, #90 WITH 1 REFILL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
MUSCLE RELAXANTS FOR PAIN.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
MUSCLE RELAXANTS Page(s): 63.

Decision rationale: The requested prescription of Skelaxin 800 mg #90 with 1 refill is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend the long term use of muscle relaxants in the management of chronic pain. The California Medical Treatment Utilization Schedule recommends short durations of treatment not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation submitted for review indicates that the injured worker has been on this medication since at least 10/2012. As the injured worker has been on this medication for an extended duration, continued use would not be supported. Additionally, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested prescription of Skelaxin 800 mg #90 with 1 refill is not medically necessary or appropriate.

PRESCRIPTION OF TRAZODONE 100MG, #30 WITH 1 REFILL: 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), MENTAL ILLNESS & STRESS.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), PAIN CHAPTER, INSOMNIA TREATMENTS.

Decision rationale: The requested prescription of trazodone 100 mg #30 with 1 refill is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule

does not address insomnia related to chronic pain. The Official Disability Guidelines recommend sedating antidepressants for short durations of treatment in the management of insomnia related to chronic pain. However, an adequate assessment of the injured worker's sleep habits was not provided. Additionally, the clinical documentation does not provide any evidence that the injured worker has failed to respond to nonpharmacological interventions. The review of the home health notes documented that the injured worker slept often and did not provide any indication of a disruption in sleep patterns. Therefore, continued use of this medication would not be indicated. Additionally, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested trazodone 100 mg #30 with 1 refill is not medically necessary or appropriate.