

<b>Case Number:</b>	CM14-0115044		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	09/05/2000
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	07/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2014

### 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 and Rehabilitation and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 51-year-old individual was reportedly injured on September 5, 2000. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated May 19, 2014, indicated that there were ongoing complaints of neck pain, back pain and right lower extremity involvement. The physical examination demonstrated a 6 foot 7 inch, 215 pound individual to be normotensive. A decrease in cervical spine range of motion was noted. A slight decrease in lumbar spine range of motion was reported as well as an abnormal gait pattern. Straight leg raising was noted to be negative. Motor function was 4/5 without atrophy. Diagnostic imaging studies were not presented for review. Previous treatment included multiple medications and pain management interventions. A request had been made for medications and was not certified in the pre-authorization process on July 16, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Midrin 65/100/325mg #60 with 2 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical

Evidence: "Comparative Study of a Combination of Isometheptene Mucate, Dichloralphenazone With Acetaminophen and Sumatriptan Succinate in the Treatment of Migraine." Headache: The Journal of Head and Face Pain (2001, vol. 41, no4, pp. 391-398).

**Decision rationale:** It should be noted that this medication is not addressed in the MTUS, ACOEM or the Official Disability Guidelines. This medication is a combination of Acetaminophen, Dichloralphenazone, and Isometheptene designed to treat headaches. The complaints focus on the back and neck and there were no complaints of headache. Therefore, there is no clinical indication to prescribe medication for the clinical situation that has not been presented. This request is not medically necessary.

**Diazepam 10mg #60 with 2 refills:** 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:** This medication is a Benzodiazepine and is not recommended for, or by these guidelines. This is a second line treatment for anxiety disorders and panic disorders and neither is noted in the clinical situation presented for review. Furthermore, with its potential for abuse and the long-term efficacy have not been proven, there is no clinical indication presented to continue this medication. The medical necessity has not been established.

**Soma 350mg #60 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC, Pain Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 29.

**Decision rationale:** As outlined in the MTUS, this medication is not recommended. Furthermore, this not indicated for long-term use as noted in the guidelines. The side effect of this medication, particularly the active metabolite, places this in a category that is not amenable to the award clinical situation. Therefore, based on the clinical rationale presented and by the parameters noted in the MTUS, the medical services for this medication have not been established.

**Norco 10/325mg #80 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78.

**Decision rationale:** When noting the date of injury, the injury sustained, the interventions completed and the current complaints, there is no clinical information presented to suggest that this medication is offering any efficacy whatsoever. As noted in the MTUS, this is for the short-term management of moderate to severe breakthrough pain. This medication is being treated as an indefinite, chronic intervention with no noted efficacy or attention to the side effect profile. Furthermore, when noting the treatment plan parameters for the chronic opiate use, and requirement that certain standards be identified, and the diagnosis and other medications being employed, establishing the efficacy of the medication and documentation of functional improvement, the requirements to continue this medication as outlined in the MTUS are not met. Therefore, the medical necessity of this preparation has not been established.

**Motrin 800mg #270 with 1 refill:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

**Decision rationale:** The MTUS does suggest that this is recommended in a chronic low back pain situation. However, when noting the date of injury, the diagnosis and the lack of any documentation of that there has been any significant improvement, the efficacy of the continued use of this medication has not been established. Therefore, when noting the parameters outlined in the MTUS and by the limited clinical information presented by the treating provider in the progress notes, there is no medical necessity established for the ongoing use of this medication.

**Ambien 10mg #30 with 2 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Procedure Summary.

**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 updated July 2014.

**Decision rationale:** It is noted that neither the MTUS of the ACOEM guidelines address this medication. The parameters noted in the Official Disability Guidelines are applied. It is noted that this medication is a short acting, non-benzodiazepine hypnotic approved to address the short-term (2-6 weeks) treatment of insomnia. This is not medically chronic, indefinite medication. Therefore, the medical necessity of this preparation has not been established.

**Lyrica 150mg #30 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19, 99.

**Decision rationale:** As established in the MTUS, this medication has been documented to be effective in the treatment of diabetic neuropathy or post-herpetic neuralgia. Neither of these maladies is noted to be into play in this clinical situation. There is an off label use to use this medication to address a neuropathic component; however, there is no objectification of a specific neuropathic injury or pain generator. Therefore, the medical necessity of this medication has not been established.