

<b>Case Number:</b>	CM14-0128840		
<b>Date Assigned:</b>	08/18/2014	<b>Date of Injury:</b>	12/17/2001
<b>Decision Date:</b>	09/15/2014	<b>UR Denial Date:</b>	08/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/13/2014

### 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 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 54- year-old individual was reportedly injured on December 17, 2001. The mechanism of injury was not listed in these records reviewed; however, there is a notation in the December 4, 2013 progress note of a recent fall after missing a stool to sit upon. The most recent progress note, dated July 13 2014, indicated that there were ongoing complaints of pain in the bilateral arms, bilateral legs, cervical spine, bilateral shoulders, bilateral hips, bilateral hands, right knee and low back. The physical examination demonstrated a display of normal pain behaviors, moderate distress, and no evidence of over medication. The muscle skeletal examination noted no deformity, scoliosis, but there was a decreased range of motion. Diagnostic imaging studies were not reviewed. Previous treatment included multiple medications and pain management interventions. A request had been made for multiple medications and was not certified in the pre-authorization process on August 11, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ALPRAZOLAM 0.25MG #20:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24 of 127.

**Decision rationale:** This medication also known as Xanax, is a Benzodiazepine used for the treatment of anxiety disorders and panic disorders. All noting that there is a chronic pain disorder described, the use of Benzodiazepines long-term is not recommended, as the risk of dependence is significant. As such, as noted in the MTUS, chronic Benzodiazepine is the treatment of choice in very few conditions and this is not one of them. Therefore, based on the clinical information presented for review and by the parameters outlined in the MTUS, this request is not medically necessary.

**LIDODERM 5% PATCH #3 BOXES:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57, 112 of 127.

**Decision rationale:** MTUS guidelines support the use of topical Lidocaine for individuals with neuropathic pain that have failed treatment with first-line therapy including antidepressants or anti-epileptic medications. Based on the clinical documentation provided, the claimant has chronic pain complaints, but the progress notes did not demonstrate any efficacy or utility in terms of increased functionality, return to work or decreased symptomatology. As such, the request is not medically necessary.

**LUNESTA 3MG #30:** 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, INSOMNIA, INSOMNIA TREATMENT: MENTAL& 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, updated August 2014.

**Decision rationale:** It is noted that the MTUS and ACOEM guidelines addresses Lunesta. The parameters outlined in the ODG were applied. As noted in the ODG, the medication for insomnia is based on the etiology. A short-term intervention for such medications (4-6 weeks) is supported. With the understanding that sleep hygiene is a crucial component to the overall chronic pain management process, there is no documentation that this individual has increased sleep patterns or this medication has any efficacy whatsoever. Therefore, based on this lack of clinical information, the medical necessity for the indefinite chronic use of this medication has not been established. As such, the request is not medically necessary.

**OXYCODONE HCL 15MG #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74, 78, 93 of 127.

**Decision rationale:** MTUS guidelines support short-acting opiates for the short-term management of moderate to severe breakthrough pain. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic pain; however, there is no clinical documentation of improvement in the pain, increased functionality or a reduction in overall symptomatology with the current regimen. As such, this request is not considered medically necessary.

**ROBAXIN 500MG #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 65 of 127.

**Decision rationale:** Robaxin is a muscle relaxant intended as a 2nd line option for the short-term treatment of acute exacerbations of chronic low back pain. According to the progress notes reviewed, there is no acute exacerbation as this is a chronic back pain situation. Furthermore, there is pain throughout that did not adhere to any specific etiology or pathology. Lastly, there is no objectification of any efficacy or utility of this medication terms of reducing symptomatology. Therefore, this request is not medically necessary.