

<b>Case Number:</b>	CM14-0042641		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	08/25/2000
<b>Decision Date:</b>	12/15/2014	<b>UR Denial Date:</b>	02/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/13/2014

### 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 Family Medicine and is licensed to practice in California. 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:

This 51-year old woman reported low back and right leg pain after working on an incline on 8/25/2000. The mechanism of injury is not clearly described in the records. She had an L5-S1 laminectomy in about 2001, but continued to have pain. She has never returned to work. Treatment has included medication with long-term opioid and benzodiazepine use, physical therapy, aquatic therapy, acupuncture, TENS and massage. Current diagnoses include sciatica, low back pain, post lumbar laminectomy syndrome, lumbar disc disorder, chronic pain syndrome, and depression with anxiety. She has been taking Methadone, long-acting Morphine Sulfate, Hydrocodone, Oxycodone, Clonazepam and Diazepam since at least 2/8/12, which is the earliest clinical record which was provided to me. An 10/2/13 note from the primary treater indicates that the patient is taking Norco, Clonazepam, Entocort, Sertraline, Valium, Amrix, Ibuprofen, Methadone, Morphine Sulfate ER, Oxycodone, Levoxyl and Omeprazole. A questionnaire filled out by the patient the same visit indicates that the patient usually feels depressed and tired, and takes little pleasure in doing things, has trouble concentrating, and has difficulty sleeping. A utilization review performed 10/28/13 modified requests for multiple drugs and certified only sufficient medication to accomplish weaning of Methadone, Norco, Morphine sulfate, Oxycodone, Clonazepam and valium. The provider apparently ignored this determination and continued to prescribe or dispense all of the drugs mentioned without any attempt to taper and discontinue them. The most recent available progress note from the patient's primary treater is dated 1/16/14. He documents that the patient has nearly global (including the back, ribs, buttocks, and all four extremities) constant pain which has worsened since her last visit. An extremely limited exam is recorded which includes tenderness over the sacroiliac spine, normal mental status, and "motor testing limited by pain". Diagnoses are as listed above. The treatment plan includes requests for MRI of the thoracic and lumbar spine, request for re-

evaluation with "orthopedic/neurologist", request for authorization for epidural steroid injections and trigger point injections, and request for authorization of TENS unit supplies. Medications dispensed in the office included Norco 10/325 #60 and Clonazepam 0.5 #30. The patient was advised to continue Clonazepam 0.5 mg, Sertraline 100 mg, Valium 10 mg, Ibuprofen 800 mg, Methadone 10 mg, Flector patch and Levoxyl without change. There is no comment regarding morphine sulfate or Percocet but the treater clearly submitted requests for both of these medications which were reviewed in UR on 2/25/14. A 2/25 UR was also performed which again recommended certification of Valium 10 mg #60 for weaning.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Valium 10 MG 1 TID #60 for weaning with no refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Benzodiazepines Page(s): 60, 24. Decision based on Non-MTUS Citation UptoDate an online evidence-based review service for clinicians, ([www.uptodate.com](http://www.uptodate.com)), Diazepam: Drug information

**Decision rationale:** Valium is brand-name diazepam, which is a benzodiazepine. According to the MTUS references above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit us to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic anticonvulsant and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. According to the UptoDate reference, significant side effects of Valium include confusion, depression, drowsiness, fatigue, sleep disturbance and insomnia. Valium should be used with caution in patients who are depressed, especially if they are at risk for suicide. Valium should be used with caution in patients receiving other CNS depressants due the potential for increased sedation, and CNS depression. Opioid use should be decreased by approximately one third when the patient is taking Valium. The clinical findings in this case do not support the continued use of Valium. This patient has been taking it for years in conjunction with multiple other potentially addictive CNS depressants. She has made no functional progress during this time, and remains totally disabled. She complains of many issues that may be caused or exacerbated by Valium, including depression, fatigue, difficulty concentrating and difficulty sleeping. Her treating provider has demonstrated absolutely no intention to wean her off any of her CNS depressants, despite utilization review reports requesting that he do so. Continuing to authorize smaller amounts of Valium than requested for the purpose of weaning is clearly useless. Taking into consideration

the evidence-based citations above and the clinical findings in this case, Valium 10 mg #60 (or any other amount of Valium) is not medically necessary. It is not necessary because its use has not resulted in any functional recovery for this patient.