

<b>Case Number:</b>	CM14-0045248		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	05/24/2010
<b>Decision Date:</b>	08/18/2014	<b>UR Denial Date:</b>	03/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/01/2014

### 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 Occupational 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:

Patient is a 54-year-old male who has submitted a claim for lumbar degenerative disc disease, lumbar herniation, and insomnia associated with an industrial injury date of 05/24/2010. Medical records from 2013 to 2014 were reviewed. Patient complained of low back pain radiating to the right lower extremity, graded 9/10 in severity. Pain was relieved to 7/10 upon medication use with 50% functional improvement. Patient also had insomnia to which intake of Temazepam provided improvement in quality of sleep. He reported appearance of skin rashes after using Butrans patch. Physical examination showed a skin rash at the left anterior chest wall. Gait was antalgic with a forward flexed posture. Straight leg raise test was positive at 80 degrees at the right. Dysesthesia was noted at the right lateral calf and sole of the foot. Motor strength was graded 4/5 at right hip flexors, right knee extensors, and right extensor hallucis longus. Treatment to date has included use of a TENS unit, physical therapy, and medications such as Butrans patch, oral opioids, and Temazepam. Utilization review from 03/26/2014 denied the requests for Zohydro ER 20mg #60 and Oxycodone IR 30mg #120 because there was no evidence of pain relief or increase in function upon its use; denied Triamcinolone cream 0.1% 80g tube because it was not guideline recommended; modified the request for Temazepam 30mg #30 into #27 for the purpose of weaning since long-term use was not recommended; and denied 1 year gym membership with pool access because the intended program was not supervised by a health professional.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Zohydro ER 20mg #60: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

**Decision rationale:** As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, the earliest progress report citing the use of opioids was dated August 2013. Patient reported pain relief with 50% functional improvement upon intake of opioids. Adverse effects were not noted. Urine drug screens were likewise consistent as cited from progress reports. Guideline criteria for continuing opioid management have been met. Therefore, the request for Zohydro ER 20 mg, #60 is medically necessary.

**Oxycodone IR 30mg #120: Overturned**

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

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

**Decision rationale:** As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, the earliest progress report citing the use of opioids was dated August 2013. Patient reported pain relief with 50% functional improvement upon intake of opioids. Adverse effects were not noted. Urine drug screens were likewise consistent as cited from progress reports. Guideline criteria for continuing opioid management have been met. Therefore, the request for Oxycodone IR 30 mg, #120 is medically necessary.

**Triamcinolone cream 0.1% 80g tube: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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: US Food and Drug Administration, Triamcinolone cream.

**Decision rationale:** The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the US Food and Drug Administration was used instead. It states that topical corticosteroids are indicated for the relief of the inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses. This medication is being prescribed to help with surface sensitivity or scar formation. In this case, patient had an allergic skin reaction upon usage of Butrans patch. Physical examination showed skin rashes at the anterior chest wall. Topical corticosteroid is a reasonable treatment option at this time. However, the request failed to specify quantity to be dispensed. The request is incomplete; therefore, the request for Triamcinolone cream 0.1% 80 g tube is not medically necessary.

**Temazepam 30mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

**Decision rationale:** As stated on page 24 of CA MTUS Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use 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. In this case, patient has been on Temazepam since August 2013 for insomnia. He reported improved sleep quality upon its use. However, there was no discussion concerning sleep hygiene. Long-term use is likewise not recommended. Therefore, the request for Temazepam 30 mg, #30 is not medically necessary.

**1 year gym membership with pool access:** 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).

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

**Decision rationale:** The CA MTUS does not address this topic specifically. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Low Back Chapter, Gym Membership was used instead. It states that gym memberships are not recommended as a medical prescription unless the documented home exercise program has been ineffective and there is a need for specialized equipment; treatment needs to be monitored and administered by medical professionals. In this case, patient has ongoing gym membership program. There was no evidence that exercises would be supervised by a health professional. Progress report cited

that patient was not able to tolerate land-based exercise programs; hence, necessitating access to pool area. However, there was no further discussion concerning possible factors hampering patient's performance to land-based exercises. Need for specialized equipment likewise was not addressed. Therefore, the request for 1 year gym membership with pool access is not medically necessary.