

<b>Case Number:</b>	CM14-0065531		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	08/31/1998
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	05/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2014

### 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 50-year-old individual was reportedly injured on August 31, 1998. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated April 9, 2014, indicated that there were ongoing complaints of neck pain with radiation into the bilateral upper extremities and low back pain with radiation into the lower extremities. The physical examination demonstrated a well healed cervical surgical scar, a decrease in cervical lordosis, a muscle spasm being present and tenderness to palpation. Myofascial care points were identified. A limitation cervical spine range of motion was also noted. The lumbar spine examination noted tenderness to palpation from L3 through S1, a decrease in range of motion and increased pain with flexion or extension. A decrease in motor function was noted as to the grading was reported to be positive. Diagnostic imaging studies noted a disc lesion at L5-S1 with no nerve root compromise. Previous treatment included surgical treatment, multiple medications, physical therapy, and pain management interventions. A request had been made for multiple medications and was not certified in the pre-authorization process on May 1, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Halcion 0.25mg #60:** Upheld

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

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

**Decision rationale:** This medication is a benzodiazepine derivative and this medication is not recommended for long-term use, as the long-term effects are unproven, and there is a risk of dependence. Therefore, when noting the findings outlined in the MTUS as well as the lack of any clinical indication for continued use of this medication in the progress notes reviewed, there is insufficient data presented to support the medical necessity of this medication. As such, the request for Halcion 0.25mg #60 is not medically necessary.

**Xanax 1mg #60:** Upheld

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

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

**Decision rationale:** This medication is a benzodiazepine and is not recommended for long-term use. This one does have a particular indication for panic disorders and anxiety disorders; however, based on the current clinical assessment, there does not appear to be any issues relative to these 2 maladies. Furthermore, the physical examination notes multiple trigger points and muscle spasms demonstrating the lack of efficacy or utility of this medication. As such, based on the clinical information presented for review, the request for Xanax 1mg #60 is not medically necessary.

**MS Contin 30mg #60:** 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): 74-75, 78, 93.

**Decision rationale:** As outlined in the MTUS, this medication should be reserved for patients with chronic pain or in a continuous treatment. Furthermore, there needs to be objectification of a functional improvement, decreased pain symptomatology or return to work parameters that indicate subjectively that this medication is efficacious. One does understand that there are clinical indications, but the progress notes do not indicate how this medication is increasing the overall clinical situation. As such, based in the notes presented for review, this is not medically necessary.

**Lexapro 10mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16 & 107.

**Decision rationale:** This medication is a selective serotonin reuptake inhibitor. Selective serotonin reuptake inhibitors (SSRIs) are a class of antidepressants that inhibit serotonin reuptake without action on noradrenaline. They have not shown to be effective for low back pain; however, it has been suggested that they have a role in addressing psychological symptoms associated with chronic pain. MTUS guidelines support the use of SSRIs, and Zoloft. Review, of the available medical records, fails to document a trial and/or failure to first-line agents. As such, this request is not considered medically necessary. Additionally, there is no objectified efficacy or improvement in clinical situation with use of this medication. This would be another reason to determine the continued use of Lexapro 10mg #30 is not medically necessary.

**Soma 350mg #60:** Upheld

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

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

**Decision rationale:** Soma (Carisoprodol) is a muscle relaxing type medication whose active metabolite is Meprobamate, which is highly addictive. MTUS specifically recommends against the use of Soma due to its abuse potential. Based on the clinical documentation provided, the clinician fails to provide rationale for deviation from the chronic pain treatment guidelines. As such, the request for Soma 350mg #60 is not considered medically necessary.

**Percocet 10/325mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75.

**Decision rationale:** As outlined in the MTUS, opioids are seen as an effective method for controlling chronic pain. Continuation of opioid medications requires improved function, return to work, or some other parameter that establishes the efficacy of the medication. The guidelines also require the lowest possible dose should be prescribed so that there is improved pain and function and there needs to be ongoing review and documentation of these parameters. In this case, there is no documentation of any significant improvement. The pain levels have reportedly remained the same. To assess the functionality has not been established. Accordingly, based on

the clinical information presented and by the parameters outlined in the MTUS, the request for Percocet 10/325mg #120 is not medically necessary.

**Provigil 100mg #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 (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As outlined in the MTUS, opioids are seen as an effective method for controlling chronic pain. Continuation of opioid medications requires improved function, return to work, or some other parameter that establishes the efficacy of the medication. The guidelines also require the lowest possible dose should be prescribed so that there is improved pain and function and there needs to be ongoing review and documentation of these parameters. In this case, there is no documentation of any significant improvement. The pain levels have reportedly remained the same. To assess the functionality has not been established. Accordingly, based on the clinical information presented and by the parameters outlined in the MTUS, the request for Provigil 100mg #30 is not medically necessary.

**Lidoderm 5% #60:** 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.

**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 request for Lidoderm 5% #60 is considered not medically necessary.