

<b>Case Number:</b>	CM14-0066253		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	11/08/1991
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	04/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/09/2014

### 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, has a subspecialty in Pain Management 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 is a female patient with the date of injury of November 8, 1991. A Utilization Review was performed on April 23, 2014 and recommended modification of 1 prescription for Dilaudid 8mg, #90 to 1 prescription for Dilaudid 8mg, #68 between 4/15/2014 and 7/21/2014 and non-certification of 1 prescription for Duragesic patches 75 mcg, #15 between 4/15/2014 and 7/21/2014, 1 prescription for Valium 5mg, #30 between 4/15/2014 and 7/21/2014, and 1 prescription for Xanax 1mg, #90 between 4/15/2014 and 7/21/2014. A Progress Report dated March 28, 2014 identifies Complaints of 8/10 lumbar spine pain radiating to both hips, with associated numbness and weakness down to the bilateral legs, severe hip pain, and migraine and dizziness. Examination identifies reduced cervical and lumbar range of motion, positive bilateral sacroiliac tenderness, Patrick's, sacroiliac thrust, and Yeoman's tests. Diagnoses identify cervical spine strain, cervical myofascial pain, bilateral carpal tunnel syndrome, right trigger finger, lumbar spine status post L5-S1 fusion, lumbar disc disease, lumbar radiculopathy, lumbar facet arthropathy, migraine headaches, insomnia, and anxiety. Treatment Plan identifies provide prescriptions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Dilaudid 8mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79, 120 of 127.

**Decision rationale:** Regarding the request for Dilaudid (hydromorphone), California Pain Medical Treatment Guidelines state that Dilaudid is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the Dilaudid is improving the patient's function or pain (in terms of percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. In the absence of such documentation, the currently requested Dilaudid (hydromorphone) is not medically necessary.

**Duragesic patches 75mcg #15:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79, 44 and 47 of 127.

**Decision rationale:** Regarding the request for Duragesic (Fentanyl), Chronic Pain Medical Treatment Guidelines state Fentanyl is not recommended as a first-line therapy. The Guidelines also state it is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. Within the medical information made available for review, there is documentation of chronic pain. However, there is no mention of failure of first-line therapy. There is no mention that the patient's chronic pain requires continuous opioid analgesia and the pain cannot be managed by other means. In the absence of such information, the currently requested Duragesic is not medically necessary.

**Valium 5mg #30:** 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 of 127. Decision based on Non-MTUS Citation (ODG), Chronic Pain Chapter.

**Decision rationale:** Regarding the request for Valium, Chronic Pain Medical Treatment Guidelines state the benzodiazepines are not recommended for long-term use. Most guidelines limit their use to 4 weeks. Within the documentation available for review, it is unclear what diagnosis the Valium is being prescribed to treat. There are no subjective complaints of anxiety or panic attacks. Furthermore, there is no documentation identifying any objective functional improvement as a result of the use of the Valium. Finally, there is no indication that the Valium

is being prescribed for short-term use, as recommended by guidelines. In the absence of clarity regarding those issues, the currently requested Valium is not medically necessary.

**Xanax 1mg, #90:** 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 of 127. Decision based on Non-MTUS Citation (ODG), Chronic Pain Chapter, Benzodiazepines.

**Decision rationale:** Regarding the request for Xanax (alprazolam), Chronic Pain Medical Treatment Guidelines state the benzodiazepines are not recommended for long-term use. Most guidelines limit their use to 4 weeks. Within the documentation available for review, it is unclear what diagnosis the Xanax is being prescribed to treat. There are no subjective complaints of anxiety or panic attacks. Furthermore, there is no documentation identifying any objective functional improvement as a result of the use of the Xanax. Finally, there is no indication that the Xanax is being prescribed for short-term use, as recommended by guidelines. In the absence of clarity regarding those issues, the currently requested Xanax is not medically necessary.