

Case Number:	CM14-0199164		
Date Assigned:	12/09/2014	Date of Injury:	08/24/2008
Decision Date:	01/26/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	11/26/2014

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 Internal Medicine and is licensed to practice in District of Columbia. 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 52 year old female who sustained a work related injury on 8/24/2008. Per the most recent Primary Treating Physician's Progress Report dated 10/06/2014 the injured worker reported persistent constant pain in the lower back, 7/10 on a pain scale. The pain is described as more frequently occurring and is associated with numbness and tingling down to her feet bilaterally. The pain is made better with rest and medications and made worse with activity. Physical Examination revealed decreased range of motion of the lumbar spine and tenderness to the paraspinal muscles, right greater than left. There is decreased strength and sensation, 4/5 bilaterally, at L4, L5 and S1. Deep tendon reflexes were 2+ bilaterally at patellar and Achilles tendon. Diagnoses included lumbar spine herniation with bilateral lower extremity radiculopathy, lumbar stenosis and depression and anxiety. The plan of care included aquatic therapy, consultation with a nephrologist, medications and a urine toxicology screen. Work status is temporarily totally disabled. On 11/21/2014, Utilization Review non-certified a prescription for Xanax 0.5mg #60, based on lack of documented functional improvement or medical necessity and Lactulose 10g/15mg bottle, based on lack of medical necessity. The CA MTUS Chronic Pain Medical Treatment Guidelines and <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682338.html> were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Xanax 0.5mg #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): 24,124.

Decision rationale: Per MTUS, 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. 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 disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton, 2005). & (i) Recognize that this may take months. Benzodiazepine: Tapering is required if used for 2006) This is more dangerous than opioid withdrawal, and takes more time, with the following recommendations: (1) The recommended rate of tapering is about 1/8 to 1/10 of the daily dose every 1 to 2 weeks; (2) Rate of withdrawal should be individually tapered; (3) Tapering may take as long as a year; (4) High-dose abusers or those with poly drug abuse may need in-patient detoxification; & (5) Withdrawal can occur when a chronic user switches to a benzodiazepine with a different receptor activity. (Lee, 2002) Carisoprodol (Soma): This medication is metabolized to Meprobamate, a barbiturate. At the highest levels of barbiturate tolerance, the patient are at risk of delirium, seizures or even death with abrupt discontinuation. There is little research in terms of weaning of high dose Carisoprodol and there is no standard treatment regimen for patients with known dependence. Most treatment includes treatment for symptomatic complaints of withdrawal. Another option is to switch to phenobarbital to prevent withdrawal with subsequent tapering. A maximum dose of phenobarbital is 500 mg/day and the taper is 30 mg/day with a slower taper in an outpatient setting. Tapering should be individualized for each patient. (Boothby, 2003) (Heacock, 2004) (Washington, 2002) See also Detoxification; & Rapid detox. Per review of the clinical documentation provided, this medication does not appear to be indicated. She is documented to have a normal affect and appropriate mood for reported depression and anxiety. Per guidelines, this medication is not recommended for long term usage due to side effects and dependence.

Lactulose 10g/15mg bottle: 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: <http://www.rxlist.com/lactulose-solution-drug/indications-dosage.htm>

Decision rationale: MTUS and ACOEM do not specifically address this medication. Therefore, another source was sought. Per guidelines cited, for the prevention and treatment of portal-systemic encephalopathy, including the stages of hepatic pre-coma and coma. Controlled studies

have shown that lactulose solution therapy reduces the blood ammonia levels by 25 to 50%; this is generally paralleled by an improvement in the patients' mental state and by an improvement in EEG patterns. The clinical response has been observed in about 75% of patients, which is at least as satisfactory as that resulting from neomycin therapy. An increase in patients' protein tolerance is also frequently observed with lactulose therapy. In the treatment of chronic portal-systemic encephalopathy, lactulose has been given for over 2 years in controlled studies. This patient had no medical indication, such as constipation or hepatic encephalopathy, for this medication.