

<b>Case Number:</b>	CM15-0130010		
<b>Date Assigned:</b>	07/16/2015	<b>Date of Injury:</b>	11/04/1999
<b>Decision Date:</b>	08/25/2015	<b>UR Denial Date:</b>	06/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/06/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Emergency Medicine

### 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 injured worker (IW) is a 43 year old female who sustained an industrial injury on 11/04/1999. The mechanism of injury and initial report of injury are not found in the records reviewed. The injured worker was diagnosed as having complex regional pain syndrome. Treatment to date has included medications, pain management, an intrathecal pain pump implant in the right flank, and a spinal cord stimulator implant in the right axilla. Currently, the injured worker is concerned about her intrathecal pain pump due to redness over the implant site and a change in her symptoms. Her symptoms are those of over medication alternating with symptoms of under medication. Her lumbar pain has increased, and she has intermittent nausea but no progressive weakness or numbness. Her usual pain is unchanged in intensity and character. She complains of sharp burning and aching electric feeling of pins and needles sensation that is constant at a 7 to 10 on a scale of 0-10. Activity increases the pain and medications and therapy decrease it. She is getting a routine pump refill of her pain pump, and also was refilled for Ambien, Provigil, Baclofen, and Percocet. Her speech is clear, she is alert and oriented x 3, and her speech is clear and regular. She has a flat affect. The plan of care is for fluoroscopy of the pump site. The plan is to titrate pump downward until the situation can be fixed, and request authorization for surgical revision/replacement of intrathecal catheter and pump replacement with fluoroscopy and general anesthesia. A request for authorization was made for the following:  
1. Valium 2mg #30 with 1 refill 2. Percocet 10/325mg #60

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Valium 2mg #30 with 1 refill:** Upheld

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

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

**Decision rationale:** The requested Valium 2mg #30 with 1refill, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Benzodiazepines, Page 24, note that benzodiazepines are "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence." The injured worker has persistent pain without increased complaints of numbness. The treating physician has not documented the medical indication for continued use of this benzodiazepine medication, nor objective evidence of derived functional benefit from its previous use. The criteria noted above not having been met, Valium 2mg #30 with 1 refill is not medically necessary.