MAXIMUS Federal Services

| Case Number: | CM15-0138070 | | |
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| Date Assigned: | 07/28/2015 | Date of Injury: | 06/28/2009 |
| Decision Date: | 09/17/2015 | UR Denial Date: | 07/06/2015 |
| Priority: | Standard | Application Received: | 07/16/2015 |

## 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: Family Practice

## 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 is a 71-year-old female, who sustained an industrial injury on June 28, 2009. The mechanism of injury was a fall in which the injured worker sustained a low back injury. The injured worker was also noted to have had an industrial injury in 1991, in which she sustained a low back injury. The injured worker has had persistent low back pain since the more recent injury. The diagnoses have included lumbosacral facet arthropathy, worsening lumbar radiculopathy, lumbar stenosis, cervical radiculopathy, borderline carpal tunnel syndrome bilaterally and a cervical strain. Treatment and evaluation to date has included medications, radiological studies, MRI, electrodiagnostic studies, epidural steroid injections, lumbar medial branch blocks, lumbar radiofrequency ablation, physical therapy and a home exercise program. Work status was noted to be permanent and stationary. Current documentation dated June 1, 2015 notes that the injured worker reported neck pain, which radiated to the bilateral shoulders, shoulder blades and down the upper extremities. The pain was rated a seven-eight out of ten on the visual analogue scale with medication. The injured worker also noted low back pain, which radiated down the bilateral legs. The pain was rated a seven out of ten on the visual analogue scale with medication. The injured worker also reported anxiety. Examination of the cervical spine and upper extremities revealed no tenderness or spasms of the paracervical muscles, spinous processes, and base of the neck, base of the skull or the anterior cervical musculature. Sensation in the bilateral upper extremity was intact. Orthopedic testing of the cervical spine revealed pain. Reflexes in the biceps and brachioradialis were absent bilaterally and the triceps was a 2 plus. The treating physician's plan of care included requests for Xanax 0.5 mg # 30 and Vicodin 5-300 mg # 30.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Xanax 0.5mg #30:** Upheld

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

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

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of benzodiazepines, such as Xanax, as a treatment modality. 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. In this case, the records indicate that benzodiazepines have been used as a long-term treatment strategy for this patient's symptoms. As noted in the above-cited guidelines, long-term use is not recommended. For this reason, Xanax .5mg #30 is not medically necessary.

**Vicodin 5/300mg #30:** Upheld

**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): 76-78, 80.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the long-term use of opioids, including Vicodin. These guidelines have established criteria of the use of opioids for the ongoing management of pain. Actions should include: prescriptions from a single practitioner and from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. There should be an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. Pain assessment should include: current pain, the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. There should be evidence of documentation of the "4A's for Ongoing Monitoring." These four domains include: pain relief,

side effects, physical and psychological functioning, and the occurrence of any potentially aberrant drug-related behaviors. Further, there should be consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain that does not improve on opioids in 3 months. There should be consideration of an addiction medicine consult if there is evidence of substance misuse (Pages 76-78). Finally, the guidelines indicate that for chronic pain, the long-term efficacy of opioids is unclear. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy (Page 80). Based on the review of the medical records, there is insufficient documentation in support of these stated MTUS/Chronic Pain Medical Treatment Guidelines for the ongoing use of opioids. There is insufficient documentation of the "4A's for Ongoing Monitoring." The treatment course of opioids in this patient has extended well beyond the timeframe required for a reassessment of therapy. In summary, there is insufficient documentation to support the chronic use of an opioid in this patient. Treatment with Vicodin is not considered as medically necessary.