

<b>Case Number:</b>	CM15-0167180		
<b>Date Assigned:</b>	09/04/2015	<b>Date of Injury:</b>	01/26/2007
<b>Decision Date:</b>	10/08/2015	<b>UR Denial Date:</b>	08/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2015

### 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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

### 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 77 year old male, who sustained an industrial injury on 01-26-2007. He reported injury to the low back. The diagnoses have included lumbar sprain-strain; lumbar spondylosis; lumbar degenerative disc disease; lumbar radiculopathy; left medial meniscus injury; left knee degenerative disc disease; and depression and anxiety related to chronic pain. Treatment to date has included medications, diagnostics, ice, heat, home exercise program, knee brace, and physical therapy. Medications have included Vicodin, Gabapentin, Lorazepam, Voltaren Gel, and Ambien. A progress report from the treating physician, dated 08-03-2015, documented an evaluation with the injured worker. The injured worker reported lower back pain and radiculitis into his left knee; the pain is rated at 8-9 out of 10 on the visual analog scale; sitting for 15 minutes or standing for one-half hour, he has axial back pain, paresthesias in the tops and bottoms of his feet; he walks one mile three times a day; left knee pain; he defers surgery at this time; and he is tripping daily. Objective findings included right foot drop; and he is wearing his left knee brace. The treatment plan has included the request for Vicodin 10mg-300mg 5 times daily #150; Lorazepam 5mg, 1 four times daily #120; and Voltaren Gel 1% 100gm #1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Vicodin 10mg/300mg 5 daily #150: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain, Opioids, dosing, Opioids, long-term assessment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Opioids.

**Decision rationale:** Vicodin is the brand name version of hydrocodone and acetaminophen, which is considered a short-acting opioid. ODG does not recommend the use of opioids for shoulder pain "except for short use for severe cases, not to exceed 2 weeks." The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "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." While the treating physician does indicate a range of pain scale for the patient, it does not meet several of the prescribing guidelines, such as documenting intensity of pain after taking opioid, pain relief, increased level of function, improved quality of life, or other objective and functional outcomes, which is necessary for continued ongoing use of opioids. As such, the request for Vicodin 10mg/300mg 5 daily #150 is not medically necessary.

**Lorazepam 5mg, 1 four times daily #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness, Benzodiazepines.

**Decision rationale:** MTUS and ODG states that benzodiazepine (i.e. Lorazepam) is "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." ODG further states regarding Lorazepam "Not recommended." Medical records indicate that the patient has been on Xanax in excess of the MTUS recommendations. The medical record does not provide any extenuating circumstances to recommend exceeding the guideline recommendations. The UR modified the request to allow for weaning. As such, the request for 1 Prescription of Lorazepam 5mg, 1 four times daily #120 is not medical necessary.

**Voltaren Gel 1% 100gm #1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC Pain Procedure Summary, Flector patch.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

**Decision rationale:** MTUS and ODG recommends usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." VOLTAREN (DICLOFENAC) (RECOMMENDED FOR OA) MTUS specifically states for Voltaren Gel 1% (Diclofenac) that it is "Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder." Medical records do not indicate that the patient is being treated for osteoarthritis pain in the joints. Additionally, the records indicate that the treatment area would be for low back pain. As such, the request for Voltaren Gel 1% 100gm #1 is not medically necessary.