

<b>Case Number:</b>	CM15-0023085		
<b>Date Assigned:</b>	02/12/2015	<b>Date of Injury:</b>	12/20/2010
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	01/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2015

### 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, Arizona  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 41-year-old male who reported an injury on 10/20/2012 due to an unspecified mechanism of injury. On 01/20/2015, he presented for a followup evaluation. He reported neck and upper and lower back pain. He also reported left shoulder pain, right elbow pain, and pain in both knees with numbness into the left foot. A physical examination showed anteflexion of the head on the neck allowed for 20 degrees of flexion and 20 of extension. Rotation to the left was 30 degrees, to the right 30 degrees; lateral flexion to the left was 5 degrees, to the right 5 degrees; and anteflexion of the trunk on pelvis allowed for 30 degrees of flexion and 5 degrees of extension. Rotation to the left was 10 degrees, to the right 20 degrees and lateral flexion to the left 10 degrees and to the right 10 degrees. Tinel's test was positive in both wrists for carpal tunnel and there was paracervical tenderness noted. There was some parathoracic tenderness present from T5-7 and paralumbar tenderness from L2 to L5-S1. There was right lateral epicondylar tenderness and slight left shoulder rotator cuff tenderness. He was diagnosed with chronic lumbar back pain, chronic cervical pain, chronic bilateral upper extremity pain, chronic bilateral carpal tunnel syndrome, chronic left knee sprain, chronic right knee sprain, chronic left shoulder sprain, post-traumatic headaches, and history of chest pain associated with back pain. The treatment plan was for 1 prescription of Klonopin 1 mg and 1 prescription of Seroquel XR 150 mg. The rationale for treatment was not stated.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Klonopin 1mg #60:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines do not recommend benzodiazepines for long term use because long term efficacy is unproven and there is a risk of dependence. The documentation provided does not indicate the injured worker has had a quantitative decrease in pain or an effective improvement in function with the use of this medication to support its continuation. Also, further clarification is needed regarding how long the injured worker has been using this medication. In addition, the frequency of the medication was not stated within the request. Without this information, continuing would not support as it is only recommended for short term treatment. Therefore, the request is not supported. As such, the request is not medically necessary.

**Seroquel XR 150mg #90:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Atypical Antipsychotics.

**Decision rationale:** The Official Disability Guidelines do not recommend the use of antipsychotic medications as a first line treatment and stated that there is little evidence to support their use for conditions listed in the Official Disability Guidelines. The documentation provided for review does not state a clear rationale for the medical necessity of this medication. Also, the frequency of the medication was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.