

<b>Case Number:</b>	CM15-0046177		
<b>Date Assigned:</b>	03/18/2015	<b>Date of Injury:</b>	10/05/2000
<b>Decision Date:</b>	04/20/2015	<b>UR Denial Date:</b>	02/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/11/2015

### 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: Physical Medicine & Rehabilitation, Pain Management

### 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 57 year old female, who sustained an industrial injury on October 5, 2000. She reported her pain began as work related with an auto accident. The injured worker was diagnosed as having chronic pain syndrome, bilateral hip pain, bilateral knee pain, lumbar postlaminectomy syndrome, lumbar radiculopathy, lumbar back pain, right trochanteric bursitis, paresthesia/numbness, bilateral knees osteoarthritis, chronic insomnia, depression, and obesity. Treatment to date has included bilateral knee surgeries, lumbosacral fusion, spinal cord stimulator, nerve blocks, intrathecal pump, and medication. Currently, the injured worker complains of bilateral arms, bilateral legs, neck, left shoulder, bilateral buttocks, thoracic spine, right elbow, right hip, bilateral hands, bilateral knees, bilateral low back, bilateral ankles/feet, and groin pain. The Treating Provider's report dated February 17, 2015, noted a change in the injured worker's pain control, with diarrhea with use of the Dilaudid and current medication not being as effective for breakthrough pain as the previously approved Percocet. Current medications were listed as Percocet, Oxycontin, Zomig, Valium, Topamax, Effexor, Flector Patch, Trazadone, Cozaar, Morphine via intrathecal pump, and Meloxicam. Physical examination noted the injured worker in a motorized wheelchair, with right knee tenderness to palpation and increased pain with passive range of motion (ROM). The bilateral lower extremities were noted to have 3+ edema, the right greater than the left, with decreased range of motion (ROM) against resistance of the lower leg, right greater than left. The Provider noted the Dilaudid was discontinued due to side effects, and the Percocet was returned for breakthrough pain.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Zomig 5 mg (unspecified quantity):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-head-Triptans.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head Chapter, Triptans and Other Medical Treatment Guidelines Other Medical Treatment Guideline or Medical Evidence: [http://ihs-classification.org/en/02\\_klassifikation/02\\_teil1/01.01.00\\_migraine.html](http://ihs-classification.org/en/02_klassifikation/02_teil1/01.01.00_migraine.html).

**Decision rationale:** Regarding the request for Zomig, California MTUS does not contain criteria regarding the use of triptan medications. ODG states the triptans are recommended for migraine sufferers. The International Headache Society contains criteria for the diagnosis of migraine headaches. Within the documentation available for review, there is no indication that the patient has met the criteria for the diagnosis of migraine headaches. Additionally, there is no documentation indicating how often headaches occur, and how the headaches have responded to the use of triptan medication. In the absence of clarity regarding those issues, the currently requested Zomig is not medically necessary.

**Oxycontin 40 mg( unspecified quantity):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80, 92,124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120 of 127.

**Decision rationale:** Regarding the request for Oxycontin (oxycodone ER), California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Oxycontin (oxycodone ER) is not medically necessary.

**Valium 10 mg (unspecified quantity): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 24 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Benzodiazepines.

**Decision rationale:** Regarding the request for Valium (diazepam), Chronic Pain Medical Treatment Guidelines state the 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. 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. Within the documentation available for review, there is no documentation identifying any objective functional improvement as a result of the use of the medication and no rationale provided for long-term use of the medication despite the CA MTUS recommendation against long-term use. Benzodiazepines should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In the absence of such documentation, the currently requested Valium (diazepam) is not medically necessary.