

<b>Case Number:</b>	CM14-0128709		
<b>Date Assigned:</b>	08/20/2014	<b>Date of Injury:</b>	07/11/2013
<b>Decision Date:</b>	10/09/2014	<b>UR Denial Date:</b>	08/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/13/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Louisiana. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 43 year old female who sustained a work-related injury on 07/11/2013. Prior treatment history has included trigger point injections. Progress report dated 02/17/2014 documented the patient to have complaints of low back pain rated as 10/10 with associated numbness and tingling and sharp pain in the back of the bilateral knee with associated stiffness. She reported she is unable to perform prolonged activities due to the pain. She reported a heating pad helped out a lot and was taking naproxen bid but it not provided any relief. She was using Lidocaine-Prilocaine as well. On exam, lumbar spine range of motion is limited to 30 degrees due to pain and extension as well at 20 degrees. There is tenderness to palpation with spasms and tightness of the muscles and trigger points were active. Straight leg raise is positive on the right side in supine position at 50 degrees. The patient is diagnosed with lumbar disc disorder, lumbar radiculopathy, low back pain, and chronic pain syndrome. She was prescribed the medications listed below. There was no functional documented improvement to demonstrate the efficacy of these medications. Prior utilization review dated 08/04/2014 states the request for Clonazepam 0.5mg Twice Per Day #60 +2 Refills (Prescribed 7-25-14) is modified to certify Clonazepam 0.5 mg #60 with no refills to allow for weaning; Cyclobenzaprine 10mg Every Night As Needed #30 +2 Refills (Prescribed 7-25-14) is modified to certify Cyclobenzaprine #30 with no refills to allow for weaning; Tramadol 50mg Every 12 Hours As Needed #60 +2 Refills (Prescribed 7-25-14) is modified to certify Tramadol 50 mg #60 with no refills to allow for weaning; and Lidocaine-Prilocaine Cream 2.5-2.6% #100 Grams +2 Refills (Prescribed 7-25-14) is not certified as necessity has not been established.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CLONAZEPAM 0.5MG TWICE PER DAY #60 +2 REFILLS (PRESCRIBED 7-25-14):**

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:** According to the Chronic Pain Medical Treatment Guidelines, 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 four weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Long-term use may actually increase anxiety. In this case, the ongoing use of Clonazepam would not be considered medically appropriate and would exceed the guideline recommendation to continue the use of this medication. Therefore, the request is not medically necessary.

**CYCLOBENZAPRINE 10MG EVERY NIGHT AS NEEDED #30 +2 REFILLS (PRESCRIBED 7-25-14):: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63-66.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines allow for the use of Cyclobenzaprine for a short-term course of therapy. Mixed-evidence does not allow for a recommendation for chronic use and is not recommended to be used for longer than 2-3 weeks. In this case, the supporting documentation shows the use of cyclobenzaprine dating back to February 2014, without objective evidence of significant improvement in pain or function. The request exceeds the guideline recommendation therefore, it is not medically necessary.

**TRAMADOL 50MG EVERY 12 HOURS AS NEEDED #60 +2 REFILLS (PRESCRIBED 7-25-14):: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 76-96.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, Tramadol, an opioid, recommended as the standard of care for treatment of moderate to severe pain for short term use and long-term efficacy is unclear beyond sixteen weeks. There is no supporting documentation showing any sustainable improvement in pain or function, and long term use of opiates is not supported by current evidence based guidelines. The request is not medically necessary.

**LIDOCAINE-PRILOCAINE CREAM 2.5-2.6% #100 GRAMS +2 REFILLS  
(PRESCRIBED 7-25-14): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

**Decision rationale:** Based on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics are considered largely experimental in use with few randomized controlled trials to determine efficacy and safety. Lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. It is recommended for short-term use and there are no long-term studies of their effectiveness or safety. In this case, there is no supporting documentation of localized peripheral pain and have exceeded the guideline recommendation therefore, the request is not medically necessary.