

<b>Case Number:</b>	CM14-0211218		
<b>Date Assigned:</b>	12/24/2014	<b>Date of Injury:</b>	08/04/2004
<b>Decision Date:</b>	02/19/2015	<b>UR Denial Date:</b>	11/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/16/2014

### 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. 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 & Rehabn

### 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 64 year old male with an injury date of 08/04/04. Based on the 11/15/14 progress report provided by treating physician, the patient complains of widespread chronic pain to the middle and lower back rated 7/10 and numbness and tingling in bilateral feet, pain to the bilateral shoulders rated 6-8/10. Patient is status post partial laminectomy at T4 level on 09/25/09 with spinal cord stimulator placement, status post right shoulder hardware removal surgery on 08/15/14, status post left shoulder steroid injection on 07/31/14, status post medial branch block (level unspecified) on 09/02/14. Physical examination 11/15/14 revealed tenderness to palpation to lumbar paraspinal muscles noting well healed surgical scars, decreased sensation of the L5 dermatome bilaterally. Right shoulder range of motion is noted to be 120 degrees on abduction and flexion. The patient is currently prescribed Oxycodone IR, Oxycontin, Dexadrine ER. Diagnostic imaging included CT arthrogram of the right shoulder dated 04/07/14, significant findings include: "Displaced anchor screw is seen above the humoral head prior to injection... moderate AC joint arthropathy...thin interstitial tear extending from the articular surface... atrophy of the supraspinatus tendon." No imaging or imaging reports of lumbar complaint were provided. Patient is documented as temporarily disabled in 11/15/14 progress report. Diagnosis 11/15/14- Low back pain- Lumbar foraminal stenosis- Lumbar degenerative disc disorder- Status post laminectomy syndrome- Reactive depression- Recent right shoulder arthroscopic surgery for removal of broken screw- Status post left rotator cuff surgery with re-tear (also with fraying of the biceps tendon)- Status post spinal cord stimulator placement in 2009- Bilateral L4-L5 spinal canal stenosis. The utilization review determination being challenged is dated 11/20/14. The

rationale follows:1) Oxycontin: "The reported benefits of opioids to perform basic activities of daily living at home do not meet the four A's of opioid management... the medical records do not establish an indication for chronic opioid use in this time frame over a decade from original injury." 2) Alprazolam: "Chronic benzodiazepines are the treatment of choice for very few conditions... The medical records do not provide a rationale for an exception to this guideline." Treatment reports were provided from 03/04/14 to 11/15/14.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Oxycontin tab 20 mg, ninety count without refills, prescribed on November 8, 2014:**

Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids Page(s): 60,61;76-78;88-89.

**Decision rationale:** The patient presents with widespread chronic pain to the middle and lower back rated 7/10 and numbness and tingling in bilateral feet, pain to the bilateral shoulders rated 6-8/10. The request is for OXYCONTIN TAB 20MG, NINETY COUNT WITHOUT REFILLS, PRESCRIBED ON NOVEMBER 8 2014. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, the treater has documented, per progress report dated 11/15/14 that "the patient reports significant benefit from his analgesic medications and manageable side effects"... in the same progress report treater states "he reports his pain is neither getting better nor worse". Such conflicting and vague statements do not establish the efficacy of this medication as required by MTUS. No specific information is provided as to the quantitative reduction in the patient's pain, nor specific improvements to the patient's activities of daily living. While the patient has a complex case history and likely suffers from intractable chronic pain, the treater has not provided adequate documentation of improvement owing to the use of this medication. Therefore, the request IS NOT medically necessary.

#### **Alprazolam 1 mg, thirty count without refills, prescribed on November 8, 2014:** Upheld

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

**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 Chapter under Benzodiazepine.

**Decision rationale:** The patient presents with widespread chronic pain to the middle and lower back rated 7/10 and numbness and tingling in bilateral feet, pain to the bilateral shoulders rated 6-8/10. The request is for APRAZOLAM 1 MG, THIRTY COUNT WITHOUT REFILLS, PRESCRIBED ON NOVEMBER 8 2014. ODG-TWC, Mental Illness & Stress Chapter under Benzodiazepine: "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. Most guidelines limit use to 4 weeks. Benzodiazepines are a major cause of overdose, particularly as they act synergistically with other drugs such as opioids (mixed overdoses are often a cause of fatalities). 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 (3-14 days)." Treater has not provided reason for the request. It appears that this medication is being prescribed for a long-term basis. MTUS does not support the use of benzodiazepines for more than 2-3 weeks and the current request for a 30 day supply. There is no discussion that this is to be used for a short-term. There is no documentation of acute anxiety. The request IS NOT medically necessary.