

<b>Case Number:</b>	CM15-0011833		
<b>Date Assigned:</b>	01/29/2015	<b>Date of Injury:</b>	08/14/2003
<b>Decision Date:</b>	03/27/2015	<b>UR Denial Date:</b>	01/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/20/2015

### 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 48-year-old female who reported injury on 08/01/2003. The mechanism of injury was not provided. The documentation of 01/14/2015 revealed the injured worker had shooting pain down her right leg, with burning sensation and numb sensation, and severe cramps in her back and legs at night. The injured worker had severe back pain. The injured worker reported a 50% reduction in pain and 50% functional improvement with activities of daily living with medication versus not taking them. The pain was 4/10 with medications and 10/10 without medications. The injured worker reported depression had been improving with psychotropic medications and denied suicidal ideation. Physical examination revealed the injured worker had limited range of motion and sensory loss in the right lateral calf and bottom of her foot. The injured worker ambulated with a limp. Deep tendon reflexes were +1 at the knees and ankles bilaterally. There was 4/5 weakness in the right thigh flexion and knee extension. There were palpable muscle spasms in the lumbar spine. The diagnoses included failed L5 interbody fusion with revision, reactive depression and anxiety disorder, and insomnia due to pain. The treatment plan included refill of Dilaudid 4 mg 4 times daily as needed for pain and Ativan 2 mg as needed for panic episodes.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) prescription of Dilaudid 4mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydromorphone (Dilaudid; generic available), Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain; ongoing management Page(s): 60; 78.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker had an objective decrease in pain and objective functional benefit. However, there was a lack of documentation indicating the injured worker was being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for 1 prescription of Dilaudid 4 mg #120 is not medically necessary.

**One (1) prescription of Ativan 2mg #30: 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), Mental Illness & Stress

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines do not recommend the use of benzodiazepines as a treatment for injured workers with chronic pain for longer than 4 weeks due to a high risk of psychological and physiologic dependence. The clinical documentation submitted for review failed to provide the efficacy for the requested medication. There was a lack of documentation indicating a necessity to exceed guideline recommendations, as the treatment is recommended for less than 4 weeks. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for 1 prescription of Ativan 2 mg #30 is not medically necessary.