

<b>Case Number:</b>	CM15-0114172		
<b>Date Assigned:</b>	06/24/2015	<b>Date of Injury:</b>	05/12/2010
<b>Decision Date:</b>	07/29/2015	<b>UR Denial Date:</b>	05/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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: New York

Certification(s)/Specialty: Pediatrics, Internal Medicine

### 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 47 year old female, who sustained an industrial injury on May 12, 2010. The mechanism of injury was not provided. The injured worker has been treated for left groin complaints. The diagnoses have included left ilioinguinal neuralgia, genital femoral neuralgia, right sacroiliac joint pain, neuropathic pain and chronic pain syndrome. Treatment to date has included medications, radiological studies, radio frequency treatments, nerve blocks, dorsal column stimulator and left inguinal herniorrhaphy. Current documentation dated May 7, 2015 notes that the injured worker reported left groin pain and significant right hip pain. Her left groin pain was noted to be worse since the injured worker had to use her left leg more due to the right hip pain. The injured workers current medication regime was noted to definitely help reduce the symptoms of pain and neuropathy. Objective findings noted that the injured workers mental status was intact. Examination of the pelvis revealed a positive pelvic tilt and noted the right hip to be higher. Tenderness to palpation was noted over the left inguinal area and the right sacroiliac joint. A FABER (flexion, abduction and external rotation) test was positive on the right. The treating physician's plan of care included requests for Clonazepam 0.5 mg # 60, Dilaudid 8 mg # 20, Oxycodone IR 30 mg # 150, Tizanidine 4 mg # 120, Welbutrin SR 150 mg # 60 and Soma 350 mg # 90.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Clonazepam 0.5mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

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

**Decision rationale:** According to MTUS 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 4 weeks." According to the progress notes the IW has been using benzodiazepines for a prolonged time but without mention of a functional benefit. This request is not medically necessary and appropriate.

**Dilaudid 8mg #20:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; 4) On-Going Management; 6) When to Discontinue Opioids; 7) When to Continue Opioids for chronic pain Page(s): 78-80.

**Decision rationale:** In regards to Dilaudid the MTUS Chronic Pain Medical Treatment Guidelines discourages long term usage unless there is evidence of "ongoing review and documentation of pain relief, functional status and appropriate medication use and side effects. Pain assessment should include: current pain, the least reported pain over the period since last assessment, average pain, the intensity of pain after taking the opioid, how long it takes for pain relief and how long the pain relief lasts. Satisfactory response to treatment may be indicated by the injured worker's decreased pain level, increased level of function or improved quality of life." In this case the documentation did not note specific improvement in pain, improvement in function, the least reported pain over the period since the last assessment, the intensity of pain after taking the opioid, how long it takes for pain relief and how long the pain relief lasts. In addition, there is lack of documentation of medical rationale for the use of multiple short-acting opioids. These are necessary to meet MTUS guidelines. Therefore, the request for Dilaudid 8 mg # 20 is not medically necessary.

**Oxycodone IR 30mg #150:** 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; 4) On-Going Management; 6) When to Discontinue Opioids; 7) When to Continue Opioids for chronic pain Page(s): 78-80.

**Decision rationale:** In regards to the medication Oxycodone IR the MTUS Chronic Pain Medical Treatment Guidelines discourages long term usage unless there is evidence of "ongoing review and documentation of pain relief, functional status and appropriate medication use and side effects. Pain assessment should include: current pain, the least reported pain over the period since last assessment, average pain, the intensity of pain after taking the opioid, how long it takes for pain relief and how long the pain relief lasts. Satisfactory response to treatment may be indicated by the injured worker's decreased pain level, increased level of function or improved quality of life." In this case the documentation did not note specific improvement in pain, improvement in function, the least reported pain over the period since the last assessment, the intensity of pain after taking the opioid, how long it takes for pain relief and how long the pain relief lasts. These are necessary to meet MTUS guidelines. Therefore, the request for Oxycodone IR 30 mg # 150 is not medically necessary.

**Soma 350mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma), Muscle Relaxant.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant Page(s): 29.

**Decision rationale:** Per the MTUS Chronic Pain Medical Treatment Guidelines, Soma (carisoprodol), is not recommended and not indicated for long term use. "Carisoprodol is metabolized to meprobamate an anxiolytic that is a schedule IV controlled substance. Carisoprodol is classified as a schedule IV drug in several states but not on a federal level. It is suggested that its main effect is due to generalized sedation as well as treatment of anxiety." According to the documentation the IW had been on Soma for months and the quantity prescribed implies consistent, not episodic use for acute pain. No reports show any specific and significant improvements in pain or function as a result of Soma. Per the MTUS, Soma is not recommended for chronic pain and has habituating and abuse potential. The request for Soma 350 mg #90 is not medically necessary.

**Tizanidine 4mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 63,66.

**Decision rationale:** Regarding the medication Tizanidine the MTUS Chronic Pain Medical Treatment Guidelines recommends the drug for treatment of spasticity and that one study showed significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. In review of the records provided there was no notation of spasticity nor myofascial syndrome. Therefore the request for Tizanidine 4 mg 120 mg is not medically necessary.

**Wellbutrin SR 150mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain Page(s): 13-16, 27.

**Decision rationale:** In regards to the request for Welbutrin (anti-depressant) the MTUS Chronic Pain Medical Treatment Guidelines state that antidepressants for chronic pain are "recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated." "While bupropion has shown some efficacy in neuropathic pain there is no evidence of efficacy in patients with non-neuropathic chronic low back pain." In this case there was no clear documentation neuropathy on clinical exam nor was there any electrodiagnostic study confirming neuropathy. The progress notes do not mention efficacy or functional benefit with this medication. Therefore, the request for Welbutrin SR 150 mg # 60 is not medically necessary.