

<b>Case Number:</b>	CM15-0118739		
<b>Date Assigned:</b>	06/29/2015	<b>Date of Injury:</b>	05/09/2001
<b>Decision Date:</b>	08/24/2015	<b>UR Denial Date:</b>	06/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/19/2015

### 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

### 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 70 year old female who sustained an industrial injury on May 9, 2001. She has reported low back pain with pain to the lower extremity and has been diagnosed with complex regional pain syndrome, post-laminectomy syndrome lumbar, lower extremity neuralgia, and possible compensatory left arm pain versus migratory complex regional pain syndrome. Treatment has included medications and physical therapy. She had continued pain in her lumbar spine with moderate to severe pain past 45 degrees of flexion and 10 degrees of extension. She has positive straight leg raise bilaterally. There was significant spasm with some radiation to her lower extremity with manipulation of muscle. The treatment request included medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

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

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines; Weaning of Medications.

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

**Decision rationale:** This patient presents with low back pain with pain to the lower extremity. The current request is for Valium 5mg (unspecified quantity). The RFA is dated 05/07/15. Treatment has included surgery, medications and physical therapy. The patient's work status was not provided. MTUS guidelines state on page 24 that 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. 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. 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. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks". According to progress report 05/07/15, the patient continues to complain of severe low back pain and lower extremity burning pain. Examination revealed positive straight leg raise bilaterally, significant spasm with some radiation to her lower extremity with manipulation of muscle. It was noted that the patient is stable on her current medications which include Valium 5mg, Vicodin 5/300mg, Ibuprofen 600mg, Lidoderm patches 5%, and Glucosamine/Chondroitin DS. Without these medications the patient's pain level is 9/10 and she is unable to walk or sit for extended periods of time. She has no side effects, an opioid contract is on file and UDS is periodically administered with no instances of non-compliance. MTUS guidelines does not recommend Valium for long-term and limits use to 4 weeks. The patient has been prescribed this medication since at least 03/13/14 which does not indicate short-term use. Therefore, the request is not medically necessary.

**Ibuprofen 600mg (unspecified quantity):** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects; Ibuprofen (Motrin, Advil [otc], generic available); NSAIDs (non-steroidal anti-inflammatory drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain Anti-inflammatory medications Page(s): 22, 60.

**Decision rationale:** This patient presents with low back pain with pain to the lower extremity. The current request is for Ibuprofen 600mg (unspecified quantity). The RFA is dated 05/07/15. Treatment has included surgery, medications and physical therapy. The patient's work status was not provided. Regarding NSAIDs, MTUS for chronic pain medical treatment guidelines page 22 states: "Anti-inflammatories are the traditional first line of treatment to reduce pain, so activity and functional restoration can resume, but long-term use may not be warranted. A comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of low back pain concludes that available evidence supports the effectiveness of nonselective nonsteroidal anti-inflammatory drugs "NSAIDs" in chronic LBP and of antidepressants in chronic LBP". According to progress report 05/07/15, the patient continues to complain of severe low back pain and lower extremity burning pain. Examination revealed positive straight leg raise bilaterally, significant spasm with some radiation to her lower extremity with

manipulation of muscle. It was noted that the patient is stable on her current medications which include Valium 5mg, Vicodin 5/300mg, Ibuprofen 600mg, Lidoderm patches 5%, and Glucosamine/Chondroitin DS. Without these medications the patient's pain level is 9/10 and she is unable to walk or sit for extended periods of time. She has no side effects, an opioid contract is on file and UDS is periodically administered with no instances of non-compliance. The patient has been utilizing Ibuprofen since at least 03/13/14. It appears that the patient's medication regimen provides a decrease in pain and increase in function. The requested Ibuprofen is medically necessary.

### **Lidoderm 5%: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm patches Topical analgesic Page(s): 56-57, 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter under Lidoderm (lidocaine patch).

**Decision rationale:** This patient presents with low back pain with pain to the lower extremity. The current request is for Lidoderm 5%. The RFA is dated 05/07/15. Treatment has included surgery, medications and physical therapy. The patient's work status was not provided. MTUS guidelines page 57 states, "topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica." Page 112 also states, "Lidocaine indication: neuropathic pain recommended for localized peripheral pain". ODG guidelines, Pain (Chronic) Chapter under Lidoderm (lidocaine patch) states: "Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology...A Trial of patch treatment is recommended for a short-term period (no more than four weeks)...This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points...The area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day)...Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine patches should be discontinued." According to progress report 05/07/15, the patient continues to complain of severe low back pain and lower extremity burning pain. Examination revealed positive straight leg raise bilaterally, significant spasm with some radiation to her lower extremity with manipulation of muscle. It was noted that the patient is stable on her current medications which include Valium 5mg, Vicodin 5/300mg, Ibuprofen 600mg, Lidoderm patches 5%, and Glucosamine/Chondroitin DS. Without these medications the patient's pain level is 9/10 and she is unable to walk or sit for extended periods of time. She has no side effects, an opioid contract is on file and UDS is periodically administered with no instances of non-compliance. This patient has been prescribed Lidoderm patches 5% since at least 03/13/14. Lidocaine patches are not indicated for this patient's chief complaint of chronic lower back pain with leg component. MTUS guidelines state that Lidocaine patches are appropriate for localized peripheral neuropathic pain. This patient presents with lower back and lower extremity pain, not a localized peripheral neuropathic pain, for which Lidocaine patches are indicated. There is no documentation of other complaints for

which this medication would be considered appropriate, either. This request is not in accordance with guideline indications. Therefore, the request is not medically necessary.

**Glucosamine/chondroitin DS (unknown prescription): 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), Pain (Chronic): Glucosamine/Chondroitin.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter under Glucosamine (and Chondroitin sulfate).

**Decision rationale:** This patient presents with low back pain with pain to the lower extremity. The current request is for Glucosamine/chondroitin DS (unknown prescription). The RFA is dated 05/07/15. Treatment has included surgery, medications and physical therapy. The patient's work status was not provided. MTUS Guidelines, page 50, Chronic Pain Medical Treatment Guidelines states: "Glucosamine (and Chondroitin Sulfate): Recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis... page 50 recommends glucosamine sulfate, and chondroitin sulfate but not glucosamine hydrochloride." ODG-TWC, Pain (Chronic) Chapter under Glucosamine (and Chondroitin sulfate) states: "Recommended as an option (glucosamine sulfate only) given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. Studies have demonstrated a highly significant efficacy for crystalline glucosamine sulphate (GS) on all outcomes, including joint space narrowing, pain, mobility, safety, and response to treatment, but similar studies are lacking for glucosamine hydrochloride (GH)." The treater has not provided a reason for the request. Glucosamine and Chondroitin are recommended by MTUS and ODG for moderate arthritis, especially for knee conditions. In this case, the patient presents with chronic lower back pain with radiating leg pain. Knee arthritis is not documented in the progress reports. MTUS guidelines page 50 recommends Glucosamine for treatment of arthritis pain. Guidelines do not discuss it for inflammation or neuropathic pain. Therefore, the request is not medically necessary.