

<b>Case Number:</b>	CM15-0040491		
<b>Date Assigned:</b>	03/10/2015	<b>Date of Injury:</b>	05/31/2001
<b>Decision Date:</b>	05/28/2015	<b>UR Denial Date:</b>	02/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2015

### 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 56 year old female, who sustained an industrial injury on May 31, 2001. The injured worker reported back and leg pain. The injured worker was diagnosed as having thoracic and lumbar radiculitis, lumbosacral herniated nucleus pulposus (HNP), thoracic disc protrusion, obesity and right leg deep vein thrombosis (DVT). Treatment to date has included medications. Progress note dated January 9, 2015 the injured worker complains of low back and leg pain with numbness in the legs. Physical exam notes antalgic gait, decreased sensation in thighs and right leg swelling. The plan is to continue medications, weight loss, home exercise compliance drug urine test and continue blood clot workup for deep vein thrombosis (DVT).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325 mg #240:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Citation (Section): Opioids, criteria for use CRITERIA FOR USE OF OPIOIDS 4) On-Going Management Page(s): 78.

**Decision rationale:** The IW has been on long term opioids which is not recommended. Ongoing use of an opioid should include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. The medical records provided do not clearly document decreased pain, increased activities and lack of adverse reactions. This request is not medically necessary and appropriate.

**Ambien 12.5 mg #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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Insomnia treatment.

**Decision rationale:** Per ODG pharmacological agents for insomnia should only be used after careful evaluation of potential causes of sleep disturbance for the etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. There is no discussion of an investigation into the origin of the sleep disturbance and non-pharmacological interventions that may have been utilized. This request is not medically necessary and appropriate

**Valium 10 mg #15:** Upheld

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

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

**Decision rationale:** Benzodiazepines, like alprazolam, 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. This request is not medically necessary and appropriate.

**Zanaflex 4 mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64.

**Decision rationale:** According to guidelines tizanidine is indicated for 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 it was noted that there was no muscle spasm noted on exam. The request is not medically necessary and appropriate

**Urine toxicology screen for follow up:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, pain treatment agreement Page(s): 89.

**Decision rationale:** According to MTUS guidelines, IW's treated with opioids may be required to sign a pain treatment agreement. Part of the agreement may include urine screening for medication and illicit substances. No pain management agreement was submitted stating urinalysis was required and there was no notation of irregular behavior suggesting abuse. This request is not medically necessary and appropriate.