

<b>Case Number:</b>	CM15-0095357		
<b>Date Assigned:</b>	05/21/2015	<b>Date of Injury:</b>	11/12/2006
<b>Decision Date:</b>	07/03/2015	<b>UR Denial Date:</b>	04/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/18/2015

### 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 65 year old male who sustained an industrial injury on November 12, 2005. He has reported chronic pain, low back pain, and spasm of back muscles and has been diagnosed with insomnia, chronic pain, spasm, and low back pain. Treatment has included surgery, rest, and medications. Musculoskeletal examination noted motor strength and tone are normal. There was tenderness and limited range of motion to the cervical and lumbar spine. The treatment request included lorazepam, norco, morphine, and soma.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lorazepam 2mg #30 (per 4/07/15 order):** Overturned

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

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

**Decision rationale:** The patient was injured on 11/12/06 and presents with chronic pain, peripheral nerve disease, low back pain, spasm of back muscles, insomnia, chronic intractable pain, and spasm. The request is for LORAZEPAM 2 MG #30 for insomnia. The utilization review denial letter did not provide a rationale. The RFA is dated 04/07/15 and the patient's work status is not provided. This is the patient's initial trial of Lorazepam. MTUS guidelines state on page 24 that benzodiazepines such as Xanax 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." The patient is diagnosed with insomnia, chronic pain, spasm, and low back pain. Treatment to date has included surgery, rest, and medications. This is the patient's initial trial of this medication. Given that the patient has insomnia, a trial of Lorazepam appears reasonable. The requested Lorazepam IS medically necessary.

**Norco 10/325mg #60 (per 4/07/15 order): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78, 91, 93.

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

**Decision rationale:** The patient was injured on 11/12/06 and presents with chronic pain, peripheral nerve disease, low back pain, spasm of back muscles, insomnia, chronic intractable pain, and spasm. The request is for NORCO 10/325 MG #60 for breakthrough pain. The RFA is dated 04/07/15 and the patient's work status is not provided. The patient has been taking this medication as early as 04/07/15. Progress reports are provided from 10/02/14 to 04/16/15. MTUS Chronic Pain Medical Treatment Guidelines pages 88-89, "Criteria for use of opiates for long-term users of opiates (6 months or more)" 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, criteria for use of opiates, ongoing management also requires documentation of the 4 A's (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. MTUS page 98 also continues to state that the maximum dose of hydrocodone is 60 mg per day. The patient is diagnosed with insomnia, chronic pain, spasm, and low back pain. Treatment to date has included surgery, rest, and medications. In this case, none of the 4 A's are addressed as required by MTUS Guidelines. The treater does not provide any before-and-after medication pain scales. There are no examples of ADLs, which demonstrate medication efficacy, nor are there any discussions provided on adverse behavior/side effects. No validated instruments are used either. There are no pain management issues discussed such as CURES report, pain contract, etc. No outcome measures are provided either as required by MTUS Guidelines. The treater did not provide a urine drug screen to see if the patient is compliant with

his prescribed medications. The treating physician does not provide proper documentation that is required by MTUS Guidelines for continued opiate use. Therefore, the requested Norco IS NOT medically necessary.

**Morphine ER 30mg #90 (per 4/07/15 order): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78, 91, 93.

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

**Decision rationale:** The patient was injured on 11/12/06 and presents with chronic pain, peripheral nerve disease, low back pain, spasm of back muscles, insomnia, chronic intractable pain, and spasm. The request is for MORPHINE ER 30 MG #90. The RFA is dated 04/07/15 and the patient's work status is not provided. The patient has been taking this medication as early as 04/07/15. Progress reports are provided from 10/02/14 to 04/16/15. MTUS Chronic Pain Medical Treatment Guidelines pages 88-89, "Criteria for use of opiates for long-term users of opiates (6 months or more)" 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, criteria for use of opiates, ongoing management also requires documentation of the 4 A's (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. The patient is diagnosed with insomnia, chronic pain, spasm, and low back pain. Treatment to date has included surgery, rest, and medications. This is the patient's initial trial of this medication. In this case, none of the 4 A's are addressed as required by MTUS Guidelines. The treater does not provide any before-and-after medication pain scales. There are no examples of ADLs, which demonstrate medication efficacy, nor are there any discussions provided on adverse behavior/side effects. No validated instruments are used either. There is no pain management issues discussed such as CURES report, pain contract, etc. No outcome measures are provided either as required by MTUS Guidelines. The treater did not provide a urine drug screen to see if the patient is compliant with his prescribed medications. The treating physician does not provide proper documentation that is required by MTUS Guidelines for continued opiate use. Therefore, the requested Morphine ER IS NOT medically necessary.

**Soma 350mg #90 (per 4/07/15 order): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pan), Carisprodol (Soma).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

**Decision rationale:** The patient was injured on 11/12/06 and presents with chronic pain, peripheral nerve disease, low back pain, spasm of back muscles, insomnia, chronic intractable

pain, and spasm. The request is for SOMA 350 MG #90. The RFA is dated 04/07/15 and the patient's work status is not provided. The patient has been taking this medication as early as 10/02/14. MTUS Guidelines pages 63-66, "Carisoprodol (Soma): Neither of these formulations is recommended for longer than a 2 to 3-week period." This has been noted for sedated and relaxant effects. The patient is diagnosed with insomnia, chronic pain, spasm, and low back pain. Treatment to date has included surgery, rest, and medications. This is the patient's initial trial of this medication. MTUS recommends the requested Soma for no more than 2 to 3 weeks. In this case, the patient has been taking this medication since 10/02/14, which exceeds the 2 to 3 weeks recommended by MTUS guidelines. Furthermore, the treater requests for 90 tablets of Soma and there is no indication that this medication is for short-term use. The requested Soma IS NOT medically necessary.