

<b>Case Number:</b>	CM13-0040882		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	05/15/1987
<b>Decision Date:</b>	05/15/2014	<b>UR Denial Date:</b>	10/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### 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. The expert reviewer is Board Certified in Anesthesiologist, has a subspecialty in Anesthesiologist and is licensed to practice in Pain Medicine. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 71-year-old female who reported an injury on 05/15/1987 after she was hit in the face with a car door which reportedly caused injury to her head. The injured worker was evaluated on 09/27/2013. It was documented that she had ongoing chronic pain complaints. It was reported that the injured worker received pain relief and reported needing medications to participate in activities of daily living. It was noted that the injured worker denied any abuse or side effects or adverse effects of the medications. The injured worker medication history included MS Contin, Percocet, Soma, Xanax, Restoril, Lidoderm, and Nexium. It was noted that the injured worker was having increased pain in her jaw on that day. The injured worker's diagnoses included unspecified myalgia and myositis, and reflux sympathetic dystrophy. The injured worker's treatment plan included continuation of medications as prescribed. The injured worker was evaluated on 11/06/2013. It was documented that the injured worker had continued pain complaints and reported GERD symptoms due to medications. The injured worker's treatment plan was to continue medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RESTORIL 30MG, #15:** Upheld

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

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

**Decision rationale:** The requested Restoril 30mg #15 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not specifically address this medication. Official Disability Guidelines recommend this medication be limited to short durations of treatment in the management of insomnia related to chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 03/2012. As the injured worker has been on this medication for an extended duration, continued use would not be supported. Additionally, an adequate assessment of the injured worker's sleep hygiene requiring continued use of pharmacological interventions was not provided. Also, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Restoril 30 mg #15 is not medically necessary or appropriate.

**PERCOCET 5/325MG, #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

**Decision rationale:** The requested Percocet 5/325 mg #120 is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended duration. The California Medical Treatment Utilization Schedule recommends ongoing use of opioids in the management of chronic pain be supported by documentation of functional benefit, managed side effects, evidence of pain relief, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not adequately assess the injured worker's pain relief as a result of medication usage. Additionally, there is no documentation of functional benefit or evidence that the injured worker is monitored for aberrant behavior. Also, the request as it is submitted does not clearly identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Percocet 5/325 mg #120 is not medically necessary or appropriate.

**NEXIUM 20MG, #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk, Page(s): 68.

**Decision rationale:** The requested Nexium 20 mg #30 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the use of gastrointestinal protectants for injured workers who are at risk for developing gastrointestinal events related to medication usage. The clinical documentation submitted for review does indicate that the injured worker has complaints of gastrointestinal events possibly related to medication usage. However, there was not an adequate assessment of the injured worker's risk factors to support that the injured worker's symptoms may be related to medication usage. Therefore, the appropriateness of this medication cannot be determined. Additionally, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Nexium 20 mg #30 is not medically necessary or appropriate.

**BENZAPRIL 40MG, #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Website: [www.drugs.com-antihypertensive](http://www.drugs.com-antihypertensive).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Diabetes Chapter, Hypertension Treatments.

**Decision rationale:** The requested Benzapril 40 mg #30 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this medication. The Official Disability Guidelines recommend this medication as a first-line treatment in the management of hypertension. The clinical documentation, however, does not provide an adequate assessment of the injured worker's cardiovascular system to support continued use of this medication. Additionally, there is no history of a significant fluctuation in the injured worker's blood pressure to support the need for this medication. As such, the requested Benzapril 40 mg #30 is not medically necessary or appropriate.