

<b>Case Number:</b>	CM14-0198026		
<b>Date Assigned:</b>	12/08/2014	<b>Date of Injury:</b>	08/06/2008
<b>Decision Date:</b>	01/23/2015	<b>UR Denial Date:</b>	11/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2014

### 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 Occupational Medicine, and is licensed to practice in California. 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 applicant is a represented [REDACTED] employee, who has filed a claim for chronic knee pain reportedly associated with an industrial injury of August 6, 2008. In a Utilization Review Report dated November 14, 2014, the claims administrator approved request for Percocet, denied a request for Duexis, approved a request for OxyContin, and denied a request for Restoril. The claims administrator stated that its decision was based on a progress note dated November 10, 2014. The claims administrator noted that the applicant seemingly carried primary diagnosis of osteoarthritis of the knee. The applicant's attorney subsequently appealed. In a progress note dated March 3, 2014, the applicant reported ongoing complaints of knee pain with derivative complaints of depression. The applicant was reportedly using Percocet, OxyContin, Elavil and Duexis, it was acknowledged, at this point in time. A 5 to 6/10 pain with opioid medications versus 10/10 without medications was appreciated. Both knee, shoulder, low back pain complaints are appreciated, exacerbated by sitting, standing, walking, kneeling, bending, lying down, and lifting. The applicant was apparently given a handicapped placard. Multiple medications were renewed. The applicant exhibited a visibly antalgic gait. The applicant was not working, it was acknowledged. The applicant was placed off of work, on total temporary disability. On June 23, 2014, the applicant again reported ongoing issues with chronic knee, shoulder, and low back pain. The applicant again reported difficulty sleeping, standing, walking, sitting, lying down, lifting, despite ongoing medication consumption. The applicant was not working. A 5-6/10 pain with medications versus 10/10 pain without medications was evident. The applicant nevertheless posited that her medications were beneficial. There was no mention of issues with reflux or heartburn, either on the body of the report or in the review of systems section of the same. Multiple medications were refilled while the applicant was again placed off of work, on total temporary disability. On August 26, 2014, the

applicant stated that the applicant was using Percocet at a rate of six tablets a day. Multifocal complaints of knee, low back and shoulder pain were noted. The applicant was again placed off of work, on total temporary disability. Shoulder corticosteroid injection therapy was sought. Multiple medications were refilled. It was stated that the applicant might ultimately require shoulder surgery. On November 10, 2014, the applicant was again placed off of work, on total temporary disability. Multiple medications were refilled. The attending provider again acknowledged that the applicant has had difficulty performing activities of daily living as basic as sitting, standing, walking, bending, lying down and lifting, despite ongoing medication consumption. It was suggested that the applicant would employ Restoril on a trial basis for difficulty sleeping due to chronic pain. The attending provider stated that she hoped to discontinue Elavil in favor of Restoril if Restoril proved more effective.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Restoril 15mg #30 1 tablet by mouth at bedtime for difficulty sleeping:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 402.

**Decision rationale:** While the MTUS Guidelines in ACOEM Chapter 15, page 402, does acknowledge that anxiolytics such as Restoril may be appropriate for "brief periods" in cases of overwhelming symptoms. In this case, however, there was no mention of the applicant having any overwhelming symptoms on or around the date Restoril was reportedly initiated, on November 10, 2014. Rather, the attending provider signaled her intention to employ Restoril for chronic, long-term, and/or scheduled use purposes on that date. The attending provider stated that she intended to employ Restoril in lieu of previously prescribed Elavil, for sedative effect purposes. This was not an ACOEM-endorsed role for Restoril, a benzodiazepine anxiolytic. Therefore, the request was not medically necessary.

**Duexis 800-26.6mg #90 1 tab by mouth 3 times daily:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain (updated 10/30/14) Duexis (Ibuprofen and Famotidine)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms, and Cardiovascular Risk topic Page(s): 69.

**Decision rationale:** Duexis, per the National Library of Medicine (NLM) is an amalgam of ibuprofen and famotidine. While page 69 of the MTUS Chronic Pain Medical Treatment Guidelines does suggest that H2 antagonists such as famotidine can be employed to combat issues with NSAID-induced dyspepsia, in this case, however, multiple progress notes, referenced

above, contained no references to issues of reflux, heartburn, and/or dyspepsia either NSAID-induced or stand-alone. It is not clearly stated why provision of Duexis was preferable to provision of nonselective-such as Motrin and Naprosyn. It is further noted that request for Duexis did represent renewal request for same. The applicant had, however, failed to demonstrate any significant benefit or functional improvement despite ongoing Duexis usage. The applicant remained off of work, on total temporary disability, despite usage of Duexis for span of several months. The applicant remained dependent on opioid agents such as OxyContin and Percocet, despite ongoing Duexis usage. The applicant continued to report difficulty performing activities of daily living as basic as standing, walking, lifting, bending, and lifting, etc., despite ongoing Duexis usage. All the foregoing, taken together, suggests a lack of functional improvement as defined in MTUS, despite ongoing usage of Duexis. Therefore, the request was not medically necessary.