

<b>Case Number:</b>	CM14-0202533		
<b>Date Assigned:</b>	12/15/2014	<b>Date of Injury:</b>	02/23/2010
<b>Decision Date:</b>	03/06/2015	<b>UR Denial Date:</b>	11/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/03/2014

### 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. 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, Arizona  
 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 66-year-old female who reported injury on 02/23/2010. The mechanism of injury was not specified. Her relevant diagnoses include sleep apnea, left knee degenerative joint disease, left shoulder degenerative joint disease, and probable lumbar radiculitis. Her past treatments included surgery, physical therapy, and medications. On 09/24/2014, the injured worker presented for a followup status post laparoscopic left shoulder rotator cuff repair on 06/25/2014. The injured worker complained of left shoulder pain and swelling. The injured worker also complained of ongoing low back pain and stiffness as well as occasional left knee and ankle pain. The physical examination revealed markedly decreased active and passive range of motion of the left shoulder with marked left anterior deltoid swelling. Flexion was noted to be about 110 degrees actively and passively with pain. Indicated muscle strength is noted to be 4/5 in the left shoulder. There was also decreased lumbar range of motion. The injured worker has decreased left knee range of motion and decreased muscle strength. The injured worker was indicated to have a positive patellofemoral compression sign and tenderness to the left lateral ankle. Relevant medications were indicated to be Norco and temazepam. The treatment plan included postoperative physical therapy to improve mobility and decrease pain with proper icing. Norco was being dispensed for pain relief and temazepam for sleep. A rationale for the request was not provided. The Request for Authorization Form was not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Norco, dispensed 9/24/14: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

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

**Decision rationale:** The request for Retrospective Norco, dispensed 9/24/14 is not medically necessary. According to The California MTUS Guidelines, there should be ongoing review and documentation of pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant or nonadherent drug related behaviors. Monitoring of these outcomes over time should affect therapeutic decisions and provide a frame work for documentation of the clinical use of the controlled drugs. There was lack of documentation in regard to objective functional improvement and objective decrease in pain with the use of the medication. There was also lack of documentation of evidence of monitoring for aberrant or nonadherent drug related behaviors. In the absence of the above, the request would not be supported by the evidence based guidelines. However due to the nature of the drug, weaning would be recommended. As such, the request is not medically necessary.

**Temazepam Retro, dispensed 9/24/14: Upheld**

**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 request for Temazepam Retro, dispensed 9/24/14, is not medically necessary. According to The California MTUS Guidelines, benzodiazepines are not recommended for long term use as long term efficacy is unproven and there is risk of dependence. In addition, the guidelines indicate the use is limited to 4 weeks. There was lack of documentation to indicate the injured worker had an anxiety disorder, convulsions, and muscle spasms to indicate medical necessity. In addition, the guidelines state that the medication is only supported for short term use. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.