

<b>Case Number:</b>	CM15-0165956		
<b>Date Assigned:</b>	09/03/2015	<b>Date of Injury:</b>	10/19/2000
<b>Decision Date:</b>	10/06/2015	<b>UR Denial Date:</b>	08/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/24/2015

### 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: Arizona, California

Certification(s)/Specialty: Family Practice

### 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 47-year-old male who sustained an industrial injury on 10-19-00. Initial complaints and diagnoses are not available. Treatments to date include medications and neck surgery. Diagnostic studies are not addressed. Current complaints include chronic severe neck pain related to leg pain, rated at 10/10 without medications, and 7/10 with medications. Current diagnoses include lumbago, pain in the shoulder joint, unspecified disorders of the bursae and tendons of the shoulder, displacement and degeneration of cervical intervertebral disc, cervical post laminectomy syndrome, and brachial neuritis or radiculitis. In a progress note dated 07-24-15 the treating provider reports the plan of care as continued home exercise program, and medications including Restoril, Norco, and OxyContin. The requested treatments include Restoril, Norco, and OxyContin. The documentation supports that the injured worker has been on OxyContin, Norco, and Restoril since at least 01-29-15

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg quantity 30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 82-92.

**Decision rationale:** Norco is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Norco for several months in combination with Oxycontin and Oxycodone in a dose that exceeds the 120 mg of Morphine equivalent recommended by the guidelines. There was no mention of Tylenol, NSAID, Tricyclic or weaning failure. The continued use of Norco is not medically necessary.

**Oxycontin 40mg quantity 105:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 82-92.

**Decision rationale:** According to the MTUS guidelines, Oxycontin is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. The maximum Morphine equivalent dose of should not exceed 120 mg. In this case, the claimant was on Norco along with Oxycontin in a dose that exceeds 120 mg of Morphine. The continued use of Oxycontin as prescribed is not medically necessary.

**Restoril 30mg quantity 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, Insomnia.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepine Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter and pg 64.

**Decision rationale:** The MTUS guidelines do not comment on insomnia. According to the ODG guidelines, recommend that treatment be based on the etiology, with the medications. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. According to the Chronic Pain Medical Treatment Guidelines, Benzodiazepines are not recommended for long-term use because its efficacy is unproven and there is a risk of addiction. Most guidelines limit its use to 4 weeks and its range of action include: sedation, anxiolytic, anti-convulsant and muscle relaxant. In this case, the claimant was on Restoril for several months. Long-term use is not indicated. The etiology of the sleep disturbance or failure of behavioral interventions was not noted. The continued and chronic use of Restoril was not medically necessary.