

<b>Case Number:</b>	CM15-0204247		
<b>Date Assigned:</b>	10/21/2015	<b>Date of Injury:</b>	11/26/2011
<b>Decision Date:</b>	12/02/2015	<b>UR Denial Date:</b>	10/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/18/2015

### 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, Oregon, Washington  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 45 year old male, who sustained an industrial injury on 11-25-2011. The injured worker is undergoing treatment for: pain to the neck, and right upper extremity. The records indicate he had been referred to a psychiatrist for anti-depressants and a sleep aid on 9-14-2012. On 9-23-15, he reported neck pain with radiation into the base of the skull and down the right upper extremity. He rated his pain 9 out of 10 without medications and 7 out of 10 with medications. Physical examination revealed tenderness in the neck, base of the skull and right trapezius, decreased sensation at C5, C6, C8 dermatome distributions, and decreased right shoulder range of motion, decreased right elbow range of motion. There is no discussion regarding insomnia. The treatment and diagnostic testing to date has included: urine drug screen (5-13-15, 8-7-15), medications, MRI of the right shoulder (2011), multiple physical therapy sessions, MRI of the cervical spine (2012), psychotherapy sessions, electrodiagnostic studies (7-12-12), and cervical spine epidural steroid injection (2-13-13). Medications have included: Vibryd, Norco, Protonix, Restoril, Lisinopril, Neurontin, and Zoloft. The records indicate he has been utilizing Restoril since at least May 2015, possibly longer. Current work status: restricted. The request for authorization is for: Restoril 30mg capsules for 30 days' supply with 3 refills. The UR dated 10-9-2015: Modified certification of Restoril 30mg capsules quantity 15 to wean to discontinue over 2 months.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Restoril capsules 30mg for 30 days supply with three refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

**Decision rationale:** According to the CA MTUS Chronic Pain Medical Treatment Guidelines, page 24, regarding benzodiazepines, "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." In this case the exam note from 9/23/15 does not demonstrate a quantitative assessment of improvement in functional activity while on the medication. In addition there is no mention of prior response to this medication, increase in activity. Therefore the request for Restoril is not medically necessary and is not medically necessary.

**Tylenol #3 tablets 300-30mg quantity 60 for 30 days with three refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, specific drug list. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain / Opioids for chronic pain.

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, opioids (criteria for use & specific drug list): A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. The patient should have at least one physical and psychosocial assessment by the treating doctor (and a possible second opinion by a specialist) to assess whether a trial of opioids should occur. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The 4 A's for Ongoing Monitoring include analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. Opioids may be continued if the patient has returned to work and the patient has improved

function/pain. The ODG-TWC pain section comments specifically on criteria for the use of drug screening for ongoing opioid treatment. The ODG Pain / Opioids for chronic pain states "According to a major NIH systematic review, there is insufficient evidence to support the effectiveness of long-term opioid therapy for improving chronic pain, but emerging data support a dose-dependent risk for serious harms." Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. There is lack of demonstrated functional improvement, percentage of relief, return to work, or increase in activity from the exam note of 9/23/15. Therefore the request is not medically necessary.

**Anaprox DS tablets 550mg quantity 60 for 30 days supply with three refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

**Decision rationale:** Per the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 66 states that Naproxen is a non-steroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis. It is used as first line treatment but long-term use is not warranted. In this case the continued use of Naproxen is not warranted, as there is no demonstration of functional improvement from the exam note from 9/23/15. Therefore the request is not medically necessary.