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| <b>Case Number:</b>   | CM15-0211444 |                              |            |
| <b>Date Assigned:</b> | 10/30/2015   | <b>Date of Injury:</b>       | 02/26/1990 |
| <b>Decision Date:</b> | 12/18/2015   | <b>UR Denial Date:</b>       | 10/14/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/27/2015 |

### 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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative Medicine

### 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 51 [REDACTED] year old female, who sustained an industrial injury on 2-26-1990. The injured worker is being treated for right wrist injury status post 5 surgeries and complex regional pain syndrome right upper extremity. Treatment to date has included surgical intervention, splinting, medications and rest. Per the Primary Treating Physician's Progress Report dated 9-24-2015, the injured worker presented for pain management follow-up. She reported no change with the pain in the right upper extremity. She is able to complete ADLs with current meds, but she uses the left hand for most ADLs. Objective findings included allodynia to light touch and mild finger contracture. There are "typical RSD changes with edema and color." The IW has been prescribed Stadol and Restoril since at least 1-16-2015. Per the medical records dated 1-16-2015 to 9-24-2015, there is no documentation of any functional improvement including significant improvement in symptoms, or decrease in pain level with the current treatment. Work status was not documented at this visit. The plan of care included home health aide, psychological clearance and continuation of medications. Authorization was requested for Doxepin 10mg-mL #1, Lyrica 200mg #90, Stadol NS 10mg-mL #20, Tramadol ER 150mg #30 with one refill #30, and Restoril 30mg #30. On 10-14-2015, Utilization Review non-certified the request for Stadol NS 10mg-mL #20 and Restoril 30mg #30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Restoril 30 mg Qty 30: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Sleep Medication.

**Decision rationale:** Regarding the request for Restoril 30 mg Qty 30, Chronic Pain Medical Treatment Guidelines state the benzodiazepines are "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. 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." Within the documentation available for review, there is no description of the patient's sleep complaints, failure of behavioral treatment, response to medication, etc. As such, there is no clear indication for use of this medication. In light of the above issues, the currently requested Restoril 30 mg Qty 30 is not medically necessary.

**Stadol NS 10 mg/ml, Qty 20: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment.

**Decision rationale:** Regarding the request for Stadol NS 10 mg/ml, Qty 20, California Pain Medical Treatment Guidelines state that Stadol is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of objective functional improvement and percent reduction in pain or reduced NRS). As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Stadol NS 10 mg/ml, Qty 20 is not medically necessary.