

<b>Case Number:</b>	CM15-0083002		
<b>Date Assigned:</b>	05/05/2015	<b>Date of Injury:</b>	03/29/2010
<b>Decision Date:</b>	07/13/2015	<b>UR Denial Date:</b>	04/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/30/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 56 year old female, who sustained an industrial injury on 3/29/10. She reported a left shoulder injury. The injured worker was diagnosed as having left shoulder degenerative joint disease, left shoulder impingement syndrome and left bicipital tendinitis. Treatment to date has included left shoulder arthroplasty, physical therapy, oral medications including Restoril and Gralise and home exercise program. Currently, the injured worker complains of constant pain in left shoulder with some improvement, she rates the pain 6/10 without medications and 3/10 with medications. Physical exam noted limited range of motion of left shoulder with tenderness over the anterior, superior and lateral surface of the left shoulder. The treatment plan included continuation of Norco, increasing Restoril, decreasing Cymbalta, continuing Gralise and Abilify, urine drug screen and HELP functional restoration program. A request for authorization was submitted for Norco, Restoril, Gralise and HELP Functional Restoration Program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg every 4-6 hours as needed #150/mo: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Page(s): 75-80.

**Decision rationale:** Regarding the request for Norco (hydorocodone/acetaminophen), Chronic Pain Medical Treatment Guidelines state that Norco 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 some indication that Norco is reducing her pain level from 6/10 to 3/10. However, there is no indication that the medication is improving the patient's function, no documentation regarding side effects, and no discussion regarding aberrant use. 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 Norco (hydorocodone/acetaminophen) is not medically necessary.

**Restoril 30mg 1-3 QHS as needed #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** Regarding the request for Restoril (Temazepam), 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 diagnosis of anxiety or sleep disorder. Furthermore, there is no documentation identifying any objective functional improvement as a result of the use of the medication and no rationale provided for long-term use of the medication. Benzodiazepines should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In the absence of such documentation, the currently requested Restoril (Temazepam) is not medically necessary.

**Gralise 600mg 3 tablets at bedtime #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines AEDs Page(s): 16-21.

**Decision rationale:** Regarding request for Gabapentin (Gralise), Chronic Pain Medical Treatment Guidelines state that anti-epilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no documentation of neuropathic pain in the subjective complaints or on exam findings. It is unclear why the patient needs this particular formulation of long acting gabapentin. Additionally, there is no discussion regarding side effects from this medication. In the absence of such documentation, the currently requested gabapentin (Gralise) is not medically necessary.

**HELP Functional Restoration Program:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Program.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs (Functional Restoration Program) Page(s): 30-34.

**Decision rationale:** Regarding the request for a functional restoration or chronic pain program, California MTUS support these types of programs when: Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; The patient has a significant loss of ability to function independently resulting from the chronic pain; The patient is not a candidate where surgery or other treatments would clearly be warranted; The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & Negative predictors of success above have been addressed. Within the medical information available for review, there is no documentation that an adequate and thorough evaluation has been made including baseline functional testing, no statement indicating that other methods for treating the patient's pain have been unsuccessful, no statement indicating that the patient has lost the ability to function independently, and no statement indicating that there are no other treatment options available. Additionally, there is no discussion regarding motivation to change and negative predictors of success. The current request is not medically necessary.