

<b>Case Number:</b>	CM14-0214767		
<b>Date Assigned:</b>	01/07/2015	<b>Date of Injury:</b>	09/10/2001
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	11/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/22/2014

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 patient is a 55-year-old woman who sustained a work-related injury on September 10, 2001. Subsequently, the patient developed neck and arm/wrist pain. According to a progress report dated October 20, 2014, the patient complained of aching and burning neck pain located at the CT junction bilaterally, right side greater than left. The pain radiated inferiorly into the interscapular area; superiorly to the cervico-occipital area; to the right upper extremity to the level of the wrist. The patient rated the level of her pain as a 4/10 at its best and 8/10 at its best. The patient used medication intermittently in the form of diazepam for spasms and Restoril for sleep. Examination of the cervical spine revealed a definite shift to the left with a slight concavity to the right. Moderate tenderness and tightness in the paracervical musculature and trapezius with moderate tenderness extending down the trapezius into the medial scapular border. Moderate tightness in the left paravertebral musculature and trapezius and medial scapular border. Range of motion: forward flexion to 25 degrees, extension to 20 degrees, rotation 40 degrees, and LB 20 degrees. Extension and rotation to the left caused discomfort in the right; when done to the right, it caused discomfort in the left junction. Biceps and triceps were rated 5/5. carpal Tinel's was slightly positive on the right into the long digit and negative on the left. Guyon's canal and cubital Tinel's were negative bilaterally. Grasp was good on the right and slightly weak on the left. Biceps was rated 4+/5 on the right and 5/5 on the left. Biceps were rated 5/5 bilaterally. The patient was diagnosed with carpal tunnel syndrome, brachial neuritis/radiculitis, tenosynovitis hand/wrist, and displaced cervical intervertebral disc.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Diazepam 10mg #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:** According to MTUS guidelines, benzodiazepines are not recommended for long term use for pain management because of unproven long term efficacy and because of the risk of dependence. Most guidelines limit their use to 4 weeks. There is no recent documentation that the patient have insomnia. The request is not medically necessary.

**Temazepam 15mg #30:** 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:** According to ODG guidelines and in the treatment of insomnia section. "Recommend that treatment be based on the etiology, with the medications recommended below. See Insomnia. 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. (Lexi-Comp, 2008) Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning. Pharmacologic Treatment: There are four main categories of pharmacologic treatment: (1) Benzodiazepines; (2) Non-benzodiazepines; (3) Melatonin & melatonin receptor agonists; & (4) Over-the-counter medications. The majority of studies have only evaluated short-term treatment (i.e., 4 weeks) of insomnia; therefore more studies are necessary to evaluate the efficacy and safety of treatments for long-term treatment of insomnia. In 2007, the FDA requested that manufacturers of all sedative-hypnotic drugs strengthen product labeling regarding risks (i.e., severe allergic reactions and complex sleep-related behaviors, such as sleep driving). It is recommended that treatments for insomnia should reduce time to sleep onset, improve sleep maintenance, avoid residual effects and increase next-day functioning. (Morin, 2007) (Reeder, 2007) (1) Benzodiazepines: FDA-approved benzodiazepines for sleep maintenance insomnia include estazolam (ProSom), flurazepam (Dalmane), quazepam (Doral), and temazepam (Restoril). Triazolam (Halcion) is FDA-approved for sleep-onset insomnia. These medications are only recommended for short-term use due to risk of tolerance, dependence, and adverse events (daytime drowsiness, anterograde amnesia, next-day sedation, impaired cognition, impaired psychomotor function, and

rebound insomnia). These drugs have been associated with sleep-related activities such as sleep driving, cooking and eating food, and making phone calls (all while asleep). Particular concern is noted for patients at risk for abuse or addiction. Withdrawal occurs with abrupt discontinuation or large decreases in dose. Decrease slowly and monitor for withdrawal symptoms.

Benzodiazepines are similar in efficacy to benzodiazepine-receptor agonists; however, the less desirable side-effect profile limits their use as a first-line agent, particularly for long-term use."