

<b>Case Number:</b>	CM15-0110894		
<b>Date Assigned:</b>	06/17/2015	<b>Date of Injury:</b>	08/28/2007
<b>Decision Date:</b>	07/22/2015	<b>UR Denial Date:</b>	06/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2015

### 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 53-year-old female, who sustained an industrial injury on 8/28/07. The injured worker was diagnosed as having L5-S1 radiculopathy, L3-S1 degenerative disc disease, L5-S1 annular fissure, L4-S1 central canal stenosis and neural foraminal stenosis, facet hypertrophy at L3-S1, lateral meniscus tear of the right knee, right knee chondromalacia, right knee Baker's cyst, and right greater trochanter bursitis. Treatment to date has included chiropractic treatment, injections, physical therapy, psychiatric treatment, and medication. On 4/15/15, back pain was rated as 8/10 with medication and 9/10 without medication. On 5/13/15, back pain was rated as 7-8/10 with medication and 9/10 without medication. Knee pain was rated as 5/10 with medication and 6/10 without medication. The injured worker had been taking Oxycodone since at least 1/8/15. Currently, the injured worker complains of difficulty sleeping due to pain. Pain was noted in the right sided lower back that radiated to the right hip and outer aspect of the right thigh and bilateral knee pain. The treating physician requested authorization for Oxycodone 10mg #90 and Restoril 30mg #30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone 10 mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): (s) 75 and 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): (s) 44, 47, 75-79, and 120.

**Decision rationale:** Regarding the request for oxycodone, California Pain Medical Treatment Guidelines state that oxycodone 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 this medication is improving the patient's function or pain (in terms of specific examples of 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 oxycodone is not medically necessary.

**Restoril 30 mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Sleep Medication, Insomnia treatment, Benzodiazepines.

**Decision rationale:** Regarding the request for Temazepam (Restoril), 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". ODG also states "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)." Furthermore Benzodiazepines are Not Recommended as first-line medications by ODG. Within the documentation available for review, there is no thorough 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 as a first line agent. In light of the above issues, the currently requested Temazepam is not medically necessary.