

Case Number:	CM15-0128111		
Date Assigned:	07/20/2015	Date of Injury:	01/04/2013
Decision Date:	08/13/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	07/02/2015

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: Arizona, California

Certification(s)/Specialty: Family Practice

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 (IW) is a 52 year old female who sustained an industrial injury on 01/04/2013. She reported right wrist and elbow symptoms caused by the activities of her job. The injured worker was diagnosed as having right elbow epicondylitis and right wrist tendonitis. Treatment to date has included regional blocks, medications, steroid injections, psychiatric care, and physical therapy. On 11/11/2014, the injured worker complains of pain in her left forearm rated 8-10 on a scale of 1-10. Symptom diagram did not include left shoulder. Bilateral cervical stellate ganglia blocks were recommended. In the exam notes of 04/08/2015, the workers diagnosis were chronic regional pain syndrome right upper extremity, and spread of pain of chronic regional pain syndrome to left upper extremity. The IW's pain diagram on 04/08/2015 covered bilateral arms and shoulders with pain into the right neck and left chest. She also complained of insomnia. Her pain was rated an 8-10 on a scale of 1-10. On exam she had decreased response to pinprick for sharp-dull discrimination. Shoulder range of motion tolerated well. Not specifically tender. The plan of care included bilateral stellate ganglia blocks, Xanax for sleep, and Percocet for pain. A request for authorization was made for the following: 1. Retro Oxycodone-Acetaminophen 10/325mg #180 Qty: 30 days, DOS: 4/18/15, 2. Retro Temazepam 30mg capsule #30, DOS: 3/20/15, 4/21/15, 12/2/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Oxycodone-Acetaminophen 10/325mg #180 Qty: 30 days, DOS: 4/18/15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 82-92.

Decision rationale: Norco is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on opioids including Norco and Butrans for several months without significant improvement in pain or function. No one opioid is superior to another and the Percocet is not medically necessary.

Retro Temazepam 30mg capsule #30, DOS: 3/20/15, 4/21/15, 12/2/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepine Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter and insomnia- pg 64.

Decision rationale: The MTUS guidelines do not comment on insomnia. According to the ODG guidelines, insomnia medications recommend that treatment be based on the etiology, with the medications. 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. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. According to the Chronic Pain Medical Treatment Guidelines, Benzodiazepines are not recommended for long-term use because its efficacy is unproven and there is a risk of addiction. Most guidelines limit its use to 4 weeks and its range of action include: sedation, anxiolytic, anti-convulsant and muscle relaxant. In this case, the Temazepam was provided for several months. Etiology of sleep disturbance or failure of behavioral interventions was not noted. Long-term use is not indicated. The Temazepam for the dates in question is not medically necessary.