

<b>Case Number:</b>	CM14-0151393		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	06/01/2002
<b>Decision Date:</b>	10/20/2014	<b>UR Denial Date:</b>	09/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2014

### 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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Injured worker is a female with date of injury 6/1/1002. Per primary treating physician's progress report dated 8/21/2014, the injured worker complains of neck and bilateral shoulder pain. Her main complaint today is the right shoulder pain. She states the pain can be as high as a 7 or more out of 10, and with medications it drops down to a 4/10. Medications have allowed her to remain functional. They have improved the quality of life, reduced her pain and allowed her to continue working. She is working full time 48 hours a week. On examination she can abduct and flex to about 180 degrees and appears normal. She has pain with apprehension maneuvers and with external rotation. Diagnoses include 1) persistent left shoulder pain, small left anterior labral tear per MRI 8/2006 2) chronic neck and bilateral upper extremity pain worse on the right side 3) chronic right shoulder pain 4) repetitive trauma disorder of the upper extremities, EMG (Electromyography) on 9/16/2013 consistent with bilateral carpal tunnel syndrome.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultracet 37.5/325 mg, #90:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section Page(s): 74-95.

**Decision rationale:** Tramadol is a central acting synthetic opioid that exhibits opioid activity with a mechanism of action that inhibits the reuptake of serotonin and norepinephrine with side effects similar to traditional opioids. The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. The injured worker reports a significant pain reduction with the use of medications. She is also able to work full time, 48 hours per week. This is a strong indication of her functional level with the use of tramadol. There was a recent urine drug screen which was consistent with the use of tramadol. The injured worker is chronically injured and is being treated for pain management. The claims administrator notes that there is no supporting evidence of objective functional improvement with medication, but this is a chronically injured worker that is in a maintenance phase of pain management. She is functioning well, and aberrant drug behavior is not evident. The medical documentation reports that the injured worker is on chronic pain medications and she needs these medications to remain functional. The requesting physician is also taking measures to assess for aberrant behavior that may necessitate immediate discontinuation of the medications. The injured worker's opioid medication dosing has remained stable and, and she appears to be in a maintenance stage of his pain management. Medical necessity for this request has been established. Therefore, the request for Ultracet 37.5/325 mg, #90 is determined to be medically necessary.

**Lunesta 1 mg, #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Med Lett Drugs Ther. 2005 Feb 28; 47(1203): 17-9

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Insomnia section

**Decision rationale:** The MTUS Guidelines does not address the use of Lunesta. Per the Official Disability Guidelines, pharmacological agents should only be used for insomnia management 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 whereas secondary insomnia may be treated with pharmacological and/or psychological measures. The medical records do not address the timeline of the insomnia or evaluation for the causes of the insomnia. The medical records do not indicate that non-pharmacological modalities such as cognitive behavioral therapy or addressing sleep hygiene practices have been utilized prior to utilizing a pharmacological sleep aid. Medical necessity of this request has not been established. As such, the request for Lunesta 1 mg, #30 is determined to not be medically necessary.

