

Case Number:	CM14-0045663		
Date Assigned:	07/11/2014	Date of Injury:	08/31/1999
Decision Date:	08/08/2014	UR Denial Date:	03/21/2014
Priority:	Standard	Application Received:	04/03/2014

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 Physical Medicine and Rehabilitation, 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:

The injured worker is a 56-year-old female who reported an injury on 08/31/1999. The mechanism of injury was not provided for clinical review. The diagnoses included mid-back pain of the sprain/strain, low back pain, right knee sprain, left hand sprain, post-traumatic head syndrome, left wrist ganglion cyst, and major depressive disorder. Previous treatments included medication and MRI. Within the clinical note dated 04/23/2014, it was reported the injured worker complained of pain in her left hand. She reported the pain was present at all times, and unchanged. She complained of pain in her mid-back. The injured worker complained of pain in her low back, which radiated to both knees. The injured worker reported having occasional tingling and numbness in her legs to the level of her knees. She reported pain in her right knee with buckling and swelling. Upon the physical examination of the left hand and wrist, the provider noted there was no palpable tenderness or swelling. Upon examination of the mid and low back, the provider noted the injured worker had decreased sensation to pinprick on the right and left lower extremities. The provider indicated the injured worker had joint line tenderness of the right knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

One prescription of Lunesta 3mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Insomnia treatment.

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

Decision rationale: The request for Lunesta 3 mg is not medically necessary. The Official Disability Guidelines do not recommend Lunesta for long-term use, but recommend it for short-term use. The guidelines recommend that insomnia treatment be based on the etiology. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbances. Failure of sleep disturbances to resolve in a 7 to 10 day period may indicate a psychiatric or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with psychological and/or physiological measures. The specific components of insomnia should be addressed, including sleep onset, sleep maintenance, sleep quality, and next day functioning. There is a lack of documentation indicating the injured worker was treated for or diagnosed with insomnia. The guidelines recommend the utilization of Lunesta for short term use. However, the injured worker has been utilizing the medication since at least 06/2013. The request submitted failed to provide the frequency of the medication. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. Therefore, the request for Lunesta 3 mg is not medically necessary.

One prescription of Zoloft 50mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Mental Illness & Stress- antidepressants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13.

Decision rationale: The request for Zoloft 50 mg is not medically necessary. The California MTUS Guidelines recommend antidepressants as a first-line option for neuropathic pain. There is a lack of documentation indicating the injured worker was treated for or diagnosed with neuropathic pain. There is a lack of documentation indicating the efficacy of the medication, as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the injured worker had been utilizing the medication since at least 06/2013. Therefore, the request is not medically necessary.