

Case Number:	CM14-0199965		
Date Assigned:	12/10/2014	Date of Injury:	08/01/2006
Decision Date:	01/27/2015	UR Denial Date:	11/24/2014
Priority:	Standard	Application Received:	12/01/2014

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 Rehabilitation, has a subspecialty in Interventional Spine 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 patient is a 56-year-old female with a date of injury of 08/01/2006. The listed diagnoses are: 1. Sprain rotator cuff. 2. Sprain of neck. 3. Rotator cuff rupture. 4. Ulnar nerve lesion. 5. Carpal tunnel syndrome. 6. Cervical disk degeneration. 7. Lumbosacral disk degeneration. 8. Medial epicondylitis. 9. Insomnia. 10. Neurotic depression. Primary treating physician's reports dated 05/30/2014, 08/08/2014, and 12/03/2014 (addendum to 11/07/2014), were included in the documentation submitted for review. Report dated 08/08/2014 noted that the patient has complaints of bilateral shoulder, arm, and low back and leg pain. The patient was described as persistent with increased numbness and tingling with decreased grip strength at the right elbow and right hand. Physical examination revealed positive Tinel's at the medial epicondyle area revealing presence of cubital tunnel syndrome. Also there was a positive Tinel's at the wrist with positive Phalen's test. The physician documented that the prescribed medications have been helpful with providing relief of pain. The patient is permanent and stationary with future medical care. The utilization review letter dated 11/24/2014 non-certified a prescription for Eszopicolone based on insufficient evidence to support usage and Oxycodone/APAP based on no documentation to support functional improvement with the medication regimen. Progress reports from 5/30/14 through 12/3/14 were provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Eszopiclone 3mg #30: 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), Pain

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 treatments Mental Illness & Stress chapter, Lunesta.

Decision rationale: This patient presents with bilateral shoulder, arm, low back, and leg pain. The current request is for eszopiclone 3 mg #30. The utilization review denied the request stating that this medication is recommended for short-term use only. Official Disability Guidelines (ODG) guidelines Pain chapter, under Insomnia treatments states "Eszopiclone (Lunesta) has demonstrated reduced sleep latency and sleep maintenance. (Morin, 2007) The only benzodiazepine-receptor agonist FDA approved for use longer than 35 days. A randomized, double blind, controlled clinical trial with 830 primary insomnia patients reported significant improvement in the treatment group when compared to the control group for sleep latency, wake after sleep onset, and total sleep time over a 6-month period." Under the Mental Illness & Stress chapter, ODG states regarding Lunesta, "Not recommended for long-term use," recommended use of hypnotics to 3 weeks maximum in the first 2 months of injury only. Review of the medical file indicates the patient has been utilizing this medication since at least 05/30/2014. ODG recommends maximum 3 weeks of use for medications in this class. The request is not medically necessary.

Oxycod/APAP 10/325 #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, CRITERIA FOR USE OF OPIOIDS Page(s): 60-61, 76-78, 88-89.

Decision rationale: This patient presents with bilateral shoulder, arm, low back, and leg pain. The current request is for oxycodone/APAP 10/325 #120. California MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." California MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The medical file provided for review includes 3 progress reports dated 05/30/2014, 08/08/2014, and 11/07/2014. These reports provide no discussion regarding the requested oxycodone/APAP. The utilization review states that the patient has been utilizing this medication for pain and denied the request for refill stating that there is "no documentation of functional improvement with the regimen." It is unclear when this medication was initiated; however, it is clear that the patient has been taking opioid with no documentation of decrease in pain, functional improvement, or changes in ADL. The medical file also does not include urine

drug screens, discussions of aberrant behaviors or possible side effects as required by California MTUS for opiate management. In this case, the treating physician has not provided adequate documentation as required by California MTUS for the continuation of opiate management. This request is not medically necessary.