

Case Number:	CM14-0020987		
Date Assigned:	02/21/2014	Date of Injury:	01/17/2007
Decision Date:	04/14/2015	UR Denial Date:	01/03/2014
Priority:	Standard	Application Received:	01/08/2014

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. 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, Hawaii

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 55 year old male with an industrial injury dated 01/17/2007. Diagnoses includes shoulder pain and lumbar facet syndrome. Diagnostic testing has included a MRI of the lumbar spine (08/20/2007, 09/29/2011 and 01/28/2009), MRI of the right shoulder (05/19/2009), x-rays of the left knee (07/02/2010), electrodiagnostic studies (07/24/2009 and 06/17/2008), and urine drug screenings. Previous treatments have included conservative measures, medications, and multiple injections. A progress note dated 03/14/2014, reports bilateral shoulder pain without changes since last visit, and poor sleep. The objective examination revealed restricted range of motion of the lumbar spine with tenderness to palpation of the paravertebral musculature, restricted range of motion in the bilateral shoulders, and positive grind test and McMurray's test on the left knee. The treating physician is requesting Lunesta and ibuprofen which was denied by the utilization review. On 01/03/2014, Utilization Review non-certified prescriptions for Lunesta 3mg #30, and ibuprofen 600mg #60, noting the MTUS and ODG guidelines were cited. On 01/06/2014, the injured worker submitted an application for IMR for review of Norco 10/325mg #180, Lunesta 3mg #30, and ibuprofen 600mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lunesta 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 GUIDELINE (ODG).

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

Decision rationale: The patient presents with shoulder pain and poor sleep quality. The current request is for Lunesta 3mg #30. The treating physician states, Quality of sleep is poor. Take 1 at bedtime as needed. Meds refilled. (3, 6) The ODG guidelines state, Not recommended for long-term use, but recommended for short-term use. Recommend limiting use of hypnotics to three weeks maximum in the first two months of injury only, and discourage use in the chronic phase. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. In this case, it is not clear in the records provided for review how long the treating physician has prescribed this medication to the patient. The ODG guidelines only recommend this medication for short term usage in the first two months of injury and this patient is clearly in the chronic phase of care as the date of injury is 6/1/05. The ODG guidelines only recommended this medication for short term use of 3 weeks and this request is for a refill. The current request is not medically necessary and the recommendation is for denial.

Ibuprofen 600mg #60: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain (updated 11/14/13) Insomnia treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

Decision rationale: The patient presents with shoulder pain and poor sleep quality. The current request is for Ibuprofen 600mg #60. The treating physician states, He is not trying any other therapies for pain relief. With meds, pain is more tolerable and functional status increased. No refill needed for Ibuprofen today. (2, 6) The MTUS guidelines state, Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. In this case, it is not clear in the records provided for review how long the treating physician has prescribed this medication to the patient. The physician does document that the medication helps decrease the patient's pain and helps improve their ability to function as required in the MTUS on page 60. The current request is medically necessary and the recommendation is for authorization.