

<b>Case Number:</b>	CM15-0018285		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	09/06/2000
<b>Decision Date:</b>	04/01/2015	<b>UR Denial Date:</b>	12/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2015

### 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: California

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 year old female injured worker suffered and industrial injury on 9/6/2000. The diagnoses were right upper extremity complex regional pain syndrome, right carpal tunnel syndrome. The treatments were medications, acupuncture and nerve block. The treating provider reported right hand range of motion was limited. There was pain over the right wrist and forearm. The Utilization Review Determination on 12/31/2014 non-certified: 1. Lunesta 3 MG Every Hour As Needed, citing ODG. 2. Nexium 20 MG Every Day, citing MTUS. 3. Symbicort MDI As Needed, citing ODG. 4. Proventil MDI As Needed, citing ODG.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lunesta 3 MG Every Hour As Needed:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines pain chapter, under insomnia treatments pain chapter, under Eszopicolone (Lunesta).

**Decision rationale:** The patient was injured on 09/06/00 and presents with right upper extremity pain, right wrist pain, and right forearm pain. The request is for LUNESTA 3 MG EVERY HOUR AS NEEDED for insomnia. There is no RFA provided and the patients work status is unknown. The patient has been taking Lunesta as early as 06/03/14. ODG Guidelines pain chapter, under insomnia treatments section states, Eszopiclone (Lunesta) has demonstrated reduced sleep latency and sleep maintenance. The only benzodiazepine-receptor agonist FDA approved for used 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 controlled group for sleep latency, wake after sleep onset, and total sleep time over a 6-month period. ODG Guidelines pain chapter, under Eszopiclone (Lunesta), this medication is Not recommended for long-term use, but recommended for short-term use. In this case, the patient has been taking this medication since 06/03/14, which exceeds the short-term duration set by ODG guidelines. It would appear that this medication is prescribed on a long-term basis. In regards to Lunesta, ODG Guidelines do not recommend for long-term use, but recommended for short-term use. Therefore, the requested Lunesta IS NOT medically necessary.

**Nexium 20 MG Every Day:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms, and cardiovascular risk Page(s): 69.

**Decision rationale:** The patient was injured on 09/06/00 and presents with right upper extremity pain, right wrist pain, and right forearm pain. The request is for NEXIUM 20 MG EVERYDAY. There is no RFA provided and the patients work status is unknown. The patient has been taking Nexium as early as 06/03/14. MTUS Guidelines page 60 and 69 states that omeprazole is recommended with precaution for patients at risk for gastrointestinal events: 1. Age greater than 65. 2. History of peptic ulcer disease and GI bleeding or perforation. 3. Concurrent use of ASA or corticosteroid and/or anticoagulant. 4. High-dose/multiple NSAID. MTUS page 69 states, NSAIDs, GI symptoms, and cardiovascular risk: Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2 receptor antagonist or a PPI. The reason for the request is not provided. As of 12/09/14, the patient is taking Symbicort MDI, Norco, Lunesta, and Proventil MDI. The treater does not document dyspepsia or GI issues. Routine prophylactic use of PPI without documentation of gastric issues is not supported by guidelines without GI risk assessment. Given the lack of rationale for its use, the requested Nexium, IS NOT medically necessary.

**Symbicort MDI As Needed:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pulmonary (Acute & Chronic) chapter, under Symbicort (Formoterol/Budesonide).

**Decision rationale:** The patient was injured on 09/06/00 and presents with right upper extremity pain, right wrist pain, and right forearm pain. The request is for SYMBICORT MDI AS NEEDED. The utilization review denial letter did not provide a rationale. There is no RFA provided and the patients work status is unknown. The patient has been taking Symbicort MDI as early as 06/03/14. ODG Guidelines under the chapter regarding Pulmonary (Acute & Chronic) under Symbicort (Formoterol/Budesonide) state the following: Recommend combination LABA (inhaled long-acting beta2-agonists)/ICS (inhaled corticosteroids) as a first-line choice for asthma. The patient is diagnosed right upper extremity complex regional pain syndrome and right carpal tunnel syndrome. Review of the reports provided does not indicate if the patient has asthma nor do any of the reports discuss this request. Therefore, the requested Symbicort MDI IS NOT medically necessary.

**Proventil MDI As Needed:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pulmonary (Acute & Chronic) chapter, under Albuterol.

**Decision rationale:** The patient was injured on 09/06/00 and presents with right upper extremity pain, right wrist pain, and right forearm pain. The request is for PROVENTIL MDI AS NEEDED. The utilization review denial letter did not provide a rationale. There is no RFA provided and the patients work status is unknown. The patient has been taking Proventil MDI as early as 06/03/14. ODG Guidelines under the chapter regarding Pulmonary (Acute & Chronic) under Albuterol states the following: Recommend inhaled short-acting beta2-agonists as a first-line choice for asthma. The patient is diagnosed right upper extremity complex regional pain syndrome and right carpal tunnel syndrome. Review of the reports provided does not indicate if the patient has asthma nor do any of the reports discuss this request. Therefore, the requested Proventil MDI IS NOT medically necessary.