

<b>Case Number:</b>	CM15-0134042		
<b>Date Assigned:</b>	07/22/2015	<b>Date of Injury:</b>	05/11/2011
<b>Decision Date:</b>	08/25/2015	<b>UR Denial Date:</b>	07/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2015

### 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: Arizona, Texas

Certification(s)/Specialty: Internal Medicine

### 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 female with an industrial injury dated 05/11/2011. The injury is documented as occurring when she was waxing floors and fell on her back onto the machine. She experienced neck pain, low back pain and headaches. Her diagnosis is chronic cervical strain and lumbar strain. Prior treatment included physical therapy, acupuncture, diagnostics, pain management, epidural injections and medications. She presents on 06/22/2015 with complaints of chronic low back pain that radiates into the lower extremities and neck pain. She continues to complain of difficulty completing her daily activities including self-hygiene and household chores. Physical examination noted no signs of sedation and displayed no drug seeking behaviors. She ambulates with an antalgic gait using the assistance of a single point cane. There was guarding, spasm and tenderness noted in the paravertebral musculature of the cervical and lumbar spine with a decreased range of motion on flexion and extension of both. There was dysesthesia noted in the lumbar 5, sacral 1 and cervical 5 dermatome distributions bilaterally. Treatment plan included medications and MRI of lumbar spine. The treatment request for Anaprox 550 mg # 360 was authorized. The treatment request is for Lunesta (Eszopiclone) 2 mg #180 and Norco 10/325 mg #360.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #360:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 94-95.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 979220-.26 Page(s): 74-96.

**Decision rationale:** Norco 10/325mg is a combination medication including hydrocodone and acetamenophen. It is a short-acting, pure opioid agonist used for intermittent or breakthrough pain. According to the MTUS section of chronic pain regarding short-acting opioids, they should be used to improve pain and functioning. There are no trials of long-term use in patients with neuropathic pain and the long-term efficacy when used for chronic back pain is unclear. Adverse effects of opioids include drug dependence. Management of patients using opioids for chronic pain control includes ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The indication for continuing these medications include if the patient has returned to work or if the patient has improved functioning and pain. In this case, the documentation does not support that the patient has had a meaningful improvement in function or pain while taking this medication. The continued use is not medically necessary. Therefore, the request is not medically necessary.

**Lunesta (Eszopiclone) 2mg #180:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 9th edition, web.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UpToDate.com.

**Decision rationale:** The MTUS is silent regarding the use of Lunesta for chronic insomnia. The FDA has approved the use of Lunesta for treatment of insomnia (with difficulty of sleep onset). Lunesta is not approved for the long-term treatment of insomnia. When treating insomnia all patients should receive therapy for any medical condition, psychiatric illness, substance abuse or sleep disorder that may be precipitating or exacerbating the insomnia. For patients who continue to have insomnia that is severe enough to require intervention cognitive behavioral therapy (CBT) is the initial therapy that is recommended. If a patient requires a combination of behavioral therapy and medication a short acting medication is recommended for 6-8 weeks and then tapered. If the patient is still having symptoms they may require evaluation in a sleep disorder center prior to the institution of long-term medications. In this case, the documentation does not support that the patient has had the proper work-up for insomnia or that non-pharmacologic treatments have been attempted and failed. Therefore, the request is not medically necessary.