

Case Number:	CM15-0199802		
Date Assigned:	10/15/2015	Date of Injury:	11/02/1995
Decision Date:	11/30/2015	UR Denial Date:	09/18/2015
Priority:	Standard	Application Received:	10/12/2015

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: Emergency 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:

This injured worker is a 62 year old female, who sustained an industrial injury on 11-02-1995. The injured worker was diagnosed as having cubital tunnel syndrome, status post cervical spine surgery x2, right wrist sprain-strain and complex regional pain syndrome. On medical records dated 07-20-2015 and 09-09-2015 the subjective complaints were noted as right elbow pain and wrist that is associated with numbness and tingling. Pain was rated at 7-8- out of 10. Objective findings were noted as right elbow range of motion was flexion 110 degrees, extension 0, supination 60 degrees and pronation 60 degrees. Right wrist range of motion was flexion 30 degrees, extension 30 degrees, radial deviation 10 degrees and ulnar deviation 15 degrees. No sleep disturbance or sleep hygiene was noted. Urine drug screen on 03-02-2015 was noted to be consistent with medication. Treatments to date included medication. Current medications were not listed on 09-09-2015; however there were prescriptions for the following since 03-02-2015 for Butalbital-APAP-Caffeine, Norco, and Lunesta. The Utilization Review (UR) was dated 09-18-2015. A Request for Authorization was submitted. The UR submitted for this medical review indicated that the request for Butalbital-APAP-Caffeine #60, Norco 7.5mg-325 #60 were modified and Lunesta 3 mg #30 was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Butalbital/APAP/Caffeine #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Barbiturate-containing analgesic agents.

Decision rationale: Fioricet contains caffeine, acetaminophen and butalbital, a barbiturate. It may be useful for acute migraine attacks. As per MTUS chronic pain guidelines, barbiturates are not recommended for chronic pain due to high risk of dependence, risk of overuse, rebound headaches and no evidence of clinical improvement. Patient is on this medication chronically. The prescription is not consistent with short-term use. Patient is also on another medication with acetaminophen leading to risk for toxicity. Fioricet is not medically necessary.

Norco 7.5/325 #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: Norco is acetaminophen and hydrocodone, an opioid. Patient has chronically been on an opioid pain medication. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation fails all criteria. Not a single component is documented. There continues to be report of severe pain. The request is not medically necessary.

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 Guidelines (ODG), Pain (Chronic): 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(Chronic), Insomnia Treatment.

Decision rationale: There is no specific sections in the MTUS chronic pain or ACOEM guidelines that relate to this topic. Lunesta/eszopiclone is a benzodiazepine agonist approved for insomnia. As per ODG guidelines, it recommends treatment of underlying cause of sleep disturbance and recommend short course of treatment. There is no documented improvement or conservative measures attempted or anything concerning sleep. Lunesta is not medically necessary.