

<b>Case Number:</b>	CM15-0022913		
<b>Date Assigned:</b>	02/13/2015	<b>Date of Injury:</b>	11/17/2011
<b>Decision Date:</b>	05/22/2015	<b>UR Denial Date:</b>	01/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2015

### 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, Arizona  
 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 65-year-old female who reported injury on 11/17/2011. The mechanism of injury was not provided. The injured worker was noted to undergo physical therapy and surgery for the left shoulder. The documentation of 10/15/2014 revealed the injured worker had a pain level of 5 in the mid back and 6 in the neck. The injured worker was sleeping approximately 7 to 8 hours per night. The injured worker had chronic pain syndrome and secondary myofascial pain syndrome. The medications included Klonopin, Prilosec, Zanaflex, and tramadol. The physical examination revealed the injured worker had myofascial restrictions in the left levator and rhomboid groups of the cervical spine. The injured worker indicated she had a 30% reduction in pain with the current treatment plan. The treatment plan included Prilosec and gabapentin with a re-evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Eszopiclone 2mg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain/Mental Illness and Stress.

**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, Lunesta.

**Decision rationale:** The Official Disability Guidelines indicate that eszopiclone is recommended for the short-term use for the treatment of insomnia. The clinical documentation submitted for review failed to provide the efficacy for the requested med. The request as submitted failed to indicate the frequency and the quantity of the medication being requested. Given the above, the request for eszopiclone 2 mg is not medically necessary.

**Butalbutol-Acetaminophen-Caffeine 50/325/40mg tab:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents Page(s): 23.

**Decision rationale:** The California MTUS Guidelines do not recommend barbiturate containing analgesic agents for the treatment of pain. The specific rationale for the requested medication was not provided. The request as submitted failed to indicate the frequency and the quantity of medication being requested. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for Butalbutol-Acetaminophen-Caffeine 50/325/40 mg tab is not medically necessary.

**Butrans patch 5mcg/hr patch:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

**Decision rationale:** The California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker had objective pain relief. However, there was a lack of documentation of objective functional improvement and documentation the injured worker was being monitored for aberrant drug behavior. There was documentation indicating the injured worker was being monitored for side effects. The request as submitted failed to indicate the frequency and the specific quantity for the requested medication. Given the above, the request for Butrans patch 5 mcg/hr patch is not medically necessary.

**Lidoderm 5% patch:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56, 57.

**Decision rationale:** The California Medical Treatment & Utilization Schedule guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review failed to provide documentation of a trial and failure of a first line therapy. The request as submitted failed to indicate the frequency, quantity, and specific body part to be treated. Given the above, the request for Lidoderm 5% patch is not medically necessary.