

<b>Case Number:</b>	CM15-0047114		
<b>Date Assigned:</b>	03/19/2015	<b>Date of Injury:</b>	09/09/2008
<b>Decision Date:</b>	04/20/2015	<b>UR Denial Date:</b>	02/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 54 year old male who sustained an industrial injury on 09/09/2008. Diagnoses include chronic bilateral wrist symptoms worse on the right side, status post right carpal tunnel release in October of 2008, chronic right shoulder pain, full thickness tear of the rotator cuff and status post rotator cuff repair on 01/14/2014, radiating symptoms in the right side of the neck (industrially denied), chronic low back pain without significant radicular symptoms (non-industrial), chronic bilateral knee pain (industrially denied), and acromioclavicular joint arthropathy. Treatment to date has included surgery and medications. A physician progress note dated 02/06/2015 documents the injured worker has some decrease in sensation over the thumb and index fingers of the hands bilaterally. She has pain with right shoulder abduction. She also has pain with resisted wrist extension towards the elbows. She states her medications help her with activities of daily living. She can do self-care activities, and she can do dishes, laundry, and cooking for longer periods of time before having to rest because of the hand and forearm pain. Treatment requested is for Lunesta 2mg, #30, and Naproxen 550mg, #90.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lunesta 2mg #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 Chapter, Insomnia Treatment.

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

**Decision rationale:** The California MTUS and the ACOEM do not specifically address this medication. Per the official disability guidelines recommend pharmacological agents for insomnia only is used after careful evaluation of potential causes of sleep disturbance. Primary insomnia is usually addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. Pharmacological treatment consists of four main categories: Benzodiazepines, Non-benzodiazepines, Melatonin and melatonin receptor agonists and over the counter medications. Sedating antidepressants have also been used to treat insomnia however there is less evidence to support their use for insomnia, but they may be an option in patients with coexisting depression. The patient does not have the diagnosis of primary insomnia. There is also no documentation of first line insomnia treatment options such as sleep hygiene measures. Therefore, the request is not certified.

**Naproxen 550mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-Steroidal Anti-inflammatory Drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 68.

**Decision rationale:** The California chronic pain medical treatment guidelines section on NSAID therapy states: Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxen being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) This medication is recommended for the shortest period of time and at the lowest dose possible. The shortest period of time is not defined in the California MTUS. The requested dosage however exceeds recommendations for this medication per the California MTUS and thus is not certified.

