

<b>Case Number:</b>	CM14-0210068		
<b>Date Assigned:</b>	12/23/2014	<b>Date of Injury:</b>	11/18/2013
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	12/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/15/2014

### 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: Preventive Medicine, Occupational 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:

Patient is a 57 year-old male with date of injury 11/18/2013. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 09/30/2014, lists subjective complaints as pain in the right shoulder and headaches. Patient also complains of having difficulty with sleep disturbance. Objective findings: Examination of the right shoulder revealed abduction at 95 degrees, extension at 45 degrees, and flexion at 95 degrees. There was no rotator cuff tenderness or supraspinatus tenderness. There was right sternoclavicular tenderness. Diagnosis: 1. Status post head trauma. 2. Traumatic brain injury. 3. Loss of smell. 4. Tinnitus related to his head trauma. 5. Sleep disturbance related to his head trauma. 6. Chronic right shoulder pain from right shoulder sprain with sternoclavicular joint tenderness. 7. Chronic low back pain, non-industrial. 8. Chronic right leg radicular findings, non- industrial. The medical records supplied for review document that the patient has been taking the following medication for at least as far back as four months. Medication: 1. Lunesta 2mg, #30 SIG: one po qhs.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lunesta:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG

**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:** The Official Disability Guidelines do not recommend the long-term use of any class of sleep aid. The patient has been taking Lunesta longer than the maximum recommended time of 4 weeks.