

Case Number:	CM15-0110484		
Date Assigned:	06/17/2015	Date of Injury:	05/16/2002
Decision Date:	07/21/2015	UR Denial Date:	06/02/2015
Priority:	Standard	Application Received:	06/08/2015

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: New York
 Certification(s)/Specialty: Anesthesiology

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 62 year old female, who sustained an industrial injury on 5/16/2002. The mechanism of injury is unknown. The injured worker was diagnosed as having bilateral carpal tunnel syndrome with right side surgical release, bilateral pan-trapezial arthritis, left thumb stenosing tenosynovitis and chronic pain syndrome. Nerve conduction study (NCS) performed revealed moderate to severe abnormalities and bilateral upper extremities magnetic resonance imaging showed wrist inflammation and joint arthritis. Treatment to date has included surgery, thumb splint, TENS (transcutaneous electrical nerve stimulation), therapy, thumb injections and medication management. In a progress note dated 5/19/2015, the injured worker complains of right hand weakness and shooting pain and dropping things. Physical examination showed left wrist tenderness and decreased motion and grip. The treating physician is requesting Lunesta 2 mg #30, Voltaren ER 100 mg #30, Flexeril 7.5 mg #60 and Ultracet 37.5 mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lunesta 2 mg #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Insomnia treatment.

Decision rationale: Eszopicolone (Lunesta) is a prescription short-acting non-benzodiazepine sedative-hypnotic, which is recommended for short-term treatment of insomnia (two to six weeks). Benzodiazepine-receptor agonists work by selectively binding to type-1 benzodiazepine receptors in the CNS. Lunesta is indicated for the treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. According to the ODG guidelines, non-Benzodiazepine sedative-hypnotics are considered first-line medications for insomnia. All of the benzodiazepine-receptor agonists are schedule IV controlled substances, which have potential for abuse and dependency. It appears that the non-benzodiazepines have similar efficacy to the benzodiazepines with fewer side effects and short duration of action. Lunesta has demonstrated reduced sleep latency and sleep maintenance and is recommended for short-term use. In this case, there is no documentation that the patient requires long-term treatment of insomnia. Medical necessity of the requested item has not been established. The requested medication is not medically necessary.

Voltaren extended release 100 mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-71. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: According to California MTUS Guidelines, oral NSAIDs, such as Diclofenac (Voltaren), are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. The ODG states that NSAIDs are recommended for acute pain, acute low back pain (LBP), and short-term pain relief in chronic LBP. There is no evidence of long-term effectiveness for pain or function. According to the ODG, there is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain in this condition. Physicians should measure transaminases periodically in patients receiving long-term therapy with Voltaren. In this case, there is no documentation of functional benefit in the past. Medical necessity for the requested medication has not been established. The requested item is not medically necessary.

Flexeril 7.5 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: According to the reviewed literature, Cyclobenzaprine (Flexeril) is closely related to the tricyclic antidepressants. It is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. Guidelines state that this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, there are no muscle spasms documented on physical exam. There is no documentation of functional improvement from any previous use of this medication. Based on the currently available information, the medical necessity for this muscle relaxant has not been established. The requested Flexeril is not medically necessary.

Ultracet 37.5 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 93-96.

Decision rationale: The medication requested for this patient is Ultracet (Tramadol plus Acetaminophen). According to the California MTUS, Tramadol is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. The treatment of chronic pain, with any opioid, requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. According to the medical documentation there has been no indication of the medication's pain relief effectiveness and no clear documentation that the patient has responded to ongoing opioid therapy. Per California MTUS Guidelines, there have to be certain criteria followed, including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. Medical necessity for the requested medication has not been established. The requested Ultracet is not medically necessary.