

Case Number:	CM15-0129191		
Date Assigned:	07/15/2015	Date of Injury:	07/23/2012
Decision Date:	08/11/2015	UR Denial Date:	06/26/2015
Priority:	Standard	Application Received:	07/02/2015

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: Texas, Florida, 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:

The injured worker is a 61 year old male, who sustained an industrial injury on 7/23/12. The injured worker has complaints of bilateral shoulder, elbow, bilateral wrists, bilateral knees and bilateral hips pain, stiffness and weakness. Right shoulder, left shoulder, right elbow, left elbow, right wrist and hand, left wrist and hand, right knee, left knee and right and left hip examination noted there is no tenderness to palpation on any ligament, tendon or bone structures and no pain with range of motion. The diagnoses have included displacement of lumbar intervertebral disc without myelopathy. Treatment to date has included a 20 percent meniscectomy in the left knee in October 2012; physical therapy; massages; heat; ice and transcutaneous electrical nerve stimulation unit; magnetic resonance imaging (MRI) of the right shoulder on 7/22/14 showed superior labral anterior posterior tear, which was similar in appearance compared to the prior magnetic resonance imaging (MRI) on 12/19/12; magnetic resonance imaging (MRI) of the left shoulder on 7/21/14 showed superior labral anterior posterior tear that extends into the biceps anchor and is similar in appearance compared to the prior magnetic resonance imaging (MRI) on 10/11/12; magnetic resonance imaging (MRI) of the bilateral hips on 9/26/14; magnetic resonance imaging (MRI) of the left knee on 4/22/14; magnetic resonance imaging (MRI) of the right knee on 4/21/12 and fusion. The request was for eszopiclone 2mg #60 and valium 10mg #45.

IMR ISSUES, DECISIONS AND RATIONALES

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

Eszopiclone 2mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain Eszopicolone (Lunesta).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, under Lunesta.

Decision rationale: This claimant was injured about 3 years ago with subjective bilateral shoulder, elbow, bilateral wrists, bilateral knees and bilateral hips pain, stiffness and weakness. Right shoulder, left shoulder, right elbow, left elbow, right wrist and hand, left wrist and hand, right knee, left knee and right and left hip examination noted there was no tenderness to palpation on any ligament, tendon or bone structures and no pain with range of motion. The diagnoses have included displacement of lumbar intervertebral disc without myelopathy. There is not documentation of insomnia in this case, nor the duration of the Lunesta usage. Eszopiclone is a schedule 4 medicine for Insomnia also known as Lunesta. Regarding Eszopicolone (Lunesta), the MTUS is silent. The ODG, Pain section simply notes it is not recommended for long-term use, but recommended for short-term use. In this case, the use appears to be chronic, with little mention of benefit out of the sleep aid. There is insufficient evidence to support the usage in this claimant's case. The request is not medically necessary.

Valium 10mg #45: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, under Benzodiazepines.

Decision rationale: This claimant was injured about 3 years ago with subjective bilateral shoulder, elbow, bilateral wrists, bilateral knees and bilateral hips pain, stiffness and weakness. Right shoulder, left shoulder, right elbow, left elbow, right wrist and hand, left wrist and hand, right knee, left knee and right and left hip examination noted there was no tenderness to palpation on any ligament, tendon or bone structures and no pain with range of motion. The diagnoses have included displacement of lumbar intervertebral disc without myelopathy. The role for the Valium, whether it be for anxiety or muscle spasm, is not defined in the records. The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. Regarding benzodiazepine medications, the ODG notes in the Pain section: Not recommended for long-term use because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. Most guidelines limit use to 4 weeks. In this case, it appears the usage is long term, which is unsupported in the guidelines. The objective benefit from the medicine is not disclosed. The side effects are not discussed. The request is not medically necessary.