

Case Number:	CM15-0026515		
Date Assigned:	02/18/2015	Date of Injury:	06/01/2006
Decision Date:	07/01/2015	UR Denial Date:	02/03/2015
Priority:	Standard	Application Received:	02/11/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 (IW) is a 57-year-old male who sustained an industrial injury on 06/01/2006. Diagnoses include shoulder pain and lumbar facet syndrome. Treatment to date has included medications, lumbar epidural steroid injections, shoulder injections, shoulder surgery, home exercise program and physical therapy. MRI of the lumbar spine on 9/29/11 noted broad-based right L3-4 foraminal disc protrusion without impingement and a small foraminal protrusion on the right at L4-5 without neural impingement. MRI of the right shoulder on 5/19/09 showed undersurface partial tearing of the focal supraspinatus tendon and biceps tendinosis with tearing of the biceps anchor. According to the progress notes dated 1/16/15, the IW reported backache and bilateral shoulder pain. He rated his pain 4/10 with prescribed medications and 6/10 without them. His pain and activity levels were unchanged since his last visit. On examination, range of motion of the lumbar spine was limited in all planes. There was tenderness, spasms and a tight muscle band present in the bilateral paravertebral muscles. Lumbar facet loading was positive on the right and straight leg raise was positive on the left. Range of motion was restricted in the shoulders bilaterally. Medications included Dulcolax 10 mg one three times daily as needed for constipation, Ibuprofen 600 mg one twice daily as needed, Lunesta 3 mg one at bedtime as needed and Norco 10/325 mg one every four to six hours as needed for pain (max 6/day). A request was made for Norco 10/325mg, #180 which reduced his pain from 8/10 to 5/10 and Lunesta 3mg, #30 which has helped him sleep four to five hours continuously.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, #180: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for Norco (Hydrocodone/acetaminophen), California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is improving the patient's function and pain with no intolerable side effects or aberrant use. In light of the above, the currently requested Norco (Hydrocodone/acetaminophen) is medically necessary.

Lunesta 3mg, #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: Pain Chapter, Insomnia Treatment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) Chronic Pain, Sleep Medication, Insomnia treatment.

Decision rationale: Regarding the request for Lunesta, California MTUS does not address the issue. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there is no current description of the patient's insomnia, no discussion regarding what behavioral treatments have been attempted, and no statement indicating significant improvement from treatment. Furthermore, there is no indication that Lunesta is being used for short-term use as recommended by guidelines. In the absence of such documentation, the currently requested Lunesta is not medically necessary.