

<b>Case Number:</b>	CM15-0061260		
<b>Date Assigned:</b>	04/07/2015	<b>Date of Injury:</b>	05/15/2013
<b>Decision Date:</b>	05/28/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/31/2015

### 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, Washington

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 is a 46-year-old female, who sustained an industrial injury, May 15, 2013. The injured worker was diagnosed with cervical neck sprain/strain, cervical degenerative disc disease, and right carpal tunnel syndrome, Tenosynovitis of the wrist or hand, cervical radiculitis, depression, insomnia and right wrist triangular fibrocartilage degeneration. According to progress note of February 17, 2015, the injured workers chief complaint was constant neck pain that radiates to the right upper extremity and right wrist with numbness and tingling. The injured worker was having severe intolerable pain. The physical exam noted a decrease range of motion of the cervical spine. There was tenderness to palpation of the cervical paraspinal musculatures. The Finkelstein and Phalen's testing to the right wrist were positive. The treatment plan included prescriptions for Toradol, Eszopidone, Gabapentin and TENS unit patches. The Request for Authorization Form was submitted on 02/17/2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Toradol 60mg, IM injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Ketorolac (Toradol).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

**Decision rationale:** California MTUS Guidelines state ketorolac is not indicated for minor or chronic painful conditions. The injured worker has been previously treated with a Toradol injection. There was no documentation of objective functional improvement. The medical necessity has not been established in this case. Given the above, the request is not medically necessary.

**Eszopidone 1mg #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 Insomnia Treatment, 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) Chronic Pain Chapter, Insomnia Treatment.

**Decision rationale:** The Official Disability Guidelines recommend insomnia treatment based on etiology. Lunesta has demonstrated reduced sleep latency and sleep maintenance. The injured worker does not maintain a diagnosis of insomnia disorder. The guidelines do not support long term use of hypnotics. There was also no evidence of a failure of nonpharmacologic treatment. The request as submitted failed to indicate the frequency. Given the above, the request is not medically necessary.

**Gabapentin 100mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 16-19.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-19.

**Decision rationale:** The California MTUS Guidelines recommend gabapentin for neuropathic pain. In this case, the injured worker has utilized the above medication since 09/2014. There is no documentation of objective functional improvement. Given the above, the request is not medically necessary.

**TENS Patches x 2 pairs:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS (transcutaneous electrical nerve stimulation).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

**Decision rationale:** California MTUS Guidelines recommend transcutaneous electrotherapy as a noninvasive conservative option, if used as an adjunct to a program of evidence based functional restoration. There is no documentation of how often the unit is being used, as well as the outcomes in terms of pain relief and function. Additionally, TENS patches were requested in 09/2014. The medical necessity for an additional 2 pairs has not been established. Given the above, the request is not medically necessary.