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| Case Number: | CM15-0069004 | | |
| Date Assigned: | 04/16/2015 | Date of Injury: | 04/18/2000 |
| Decision Date: | 06/29/2015 | UR Denial Date: | 03/25/2015 |
| Priority: | Standard | Application Received: | 04/10/2015 |

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: 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 43-year-old male who sustained an industrial injury on 04/18/2000. The injured worker was diagnosed with shoulder joint pain and right shoulder and upper arm sprain/strain. Treatment to date was not documented except for diagnostic testing and pharmacological pain management. No surgical interventions were noted. According to the primary treating physician's progress, report on February 26, 2015 the injured worker continues to experience pain in the right shoulder. The injured worker rates his pain at the least at 7/10 and currently is 10/10, which has been unchanged from previous visits. Examination of the right shoulder demonstrated normal motor strength, tenderness with slight limitation of range of motion. Current medications are listed as Norco, Amitriptyline, Lidoderm, Lunesta, Zantac, Naproxen and Flexeril. Treatment plan consists of continuing with the medication regimen and the current request for renewal of Zantac, Flexeril, Lunesta and Naproxen.

IMR ISSUES, DECISIONS AND RATIONALES

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

FLEXERIL 10MG #60 X1 REFILL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Section Muscle Relaxants (for pain) Section Page(s): 41, 42, 63, 64.

Decision rationale: Cyclobenzaprine is recommended by the MTUS Guidelines for short periods with acute exacerbations, but not for chronic or extended use. These guidelines report that the effect of cyclobenzaprine is greatest in the first four days of treatment. Cyclobenzaprine is associated with drowsiness and dizziness. The injured worker has been taking Flexeril for an extended period, however, pain levels are increasing. Per available documentation, the injured workers pain levels were most currently rated at 7-10/10. Chronic use of cyclobenzaprine may cause dependence, and sudden discontinuation may result in withdrawal symptoms. Discontinuation should include a tapering dose to decrease withdrawal symptoms. This request however is not for a tapering dose. The request for Flexeril 10MG #60 X1 refill is determined to not be medically necessary.

LUNESTA 2MG #30 X1 REFILL: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES.

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

Decision rationale: The MTUS Guidelines do not address pharmacologic sleep aids. Per the Official Disability Guidelines, pharmacological agents should only be used for insomnia management after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically whereas secondary insomnia may be treated with pharmacological and/or psychological measures. Eszopicolone (Lunesta) has demonstrated reduced sleep latency and sleep maintenance. It is the only benzodiazepine-receptor agonist FDA approved for use longer than 35 days. A randomized, double blind, controlled clinical trial with 830 primary insomnia patients reported significant improvement in the treatment group when compared to the control group for sleep latency, wake after sleep onset, and total sleep time over a 6-month period. Side effects: dry mouth, unpleasant taste, drowsiness, dizziness. Sleep-related activities such as driving, eating, cooking and phone calling have occurred. Withdrawal may occur with abrupt discontinuation. The patient's medical records do not address the timeline of the insomnia or evaluation for the causes of the insomnia. The medical records do not indicate the use of non-pharmacological modalities such as cognitive behavioral therapy or addressing sleep hygiene practices prior to utilizing a pharmacological sleep aid. The request for Lunesta 2MG #30 X1 refill is determined to not be medically necessary.

NAPROXEN 375MG #60 X1 REFILL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Section Page(s): 67-71.

Decision rationale: The uses of NSAIDs are recommended by the MTUS Guidelines with precautions. NSAIDs are recommended to be used secondary to acetaminophen and at the lowest dose possible for the shortest period in the treatment of acute pain or acute exacerbation of chronic pain as there are risks associated with NSAIDs and the use of NSAIDs may inhibit the healing process. The injured worker has chronic injuries with no change in pain level and no acute injuries reported. The request for Naproxen 375MG #60 X1 refill is determined to not be medically necessary.

ZANTAC 150MG #60 X1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Section GI Symptoms & Cardiovascular Risk Section Page(s): 68, 69.

Decision rationale: Zantac contains ranitidine, which is an H2 receptor antagonist. The MTUS Guidelines recommend the use of a proton pump inhibitor (PPI) such as omeprazole or the use of misoprostol in patients that are at intermediate risk or a gastrointestinal event when using NSAIDs. There is no indication that the injured worker is at increased risk of gastrointestinal events. The request for Zantac 150 mg #60 X1 is determined to not be medically necessary.