

Case Number:	CM14-0119778		
Date Assigned:	08/06/2014	Date of Injury:	03/09/2007
Decision Date:	09/16/2014	UR Denial Date:	07/14/2014
Priority:	Standard	Application Received:	07/30/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations

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 female who has a date of injury of 03/09/07. The mechanism of injury is not described. She is noted to have low back pain in the center of the low back radiating to the tailbone and on occasion into the right leg down to the foot. On physical examination dated 05/05/14, she is noted to be tender over L5 centrally. Her diagnosis includes a lumbar sprain with lower extremity radiculitis. She is noted to have multi-level disc bulges throughout the lumbar spine and a right L5 radiculopathy. She is reported to have spondylolisthesis at L4-5 and L5-S1. She has a diagnosis of internal derangement of the right shoulder and supraspinatus tendonitis. Records indicate that her current medication profile includes Zolpidem 10mg, topical compounded medications, Cyclobenzaprine 10mg, Methocarbamol 750mg, Naproxen 550mg, and Omeprazole 20mg. The record includes a utilization review determination dated 07/14/14 in which requests for Lunesta 1mg #90 with 3 refills, Keratek gel 4 ounces with 3 refills, Flurbiprofen/Ranitidine 100mg/100mg #90 with 3 refills, and Tizanidine 5mg #60 with 3 refills was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lunesta 1mg # 90 with 3 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Med Lett Drugs Ther. 2005.

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.

Decision rationale: The request for Lunesta 1mg #90 with 3 refills is not supported as medically necessary. The record reports that the injured worker has used this medication as a sedative to treat insomnia. However, the record provides no data indicating that the primary causes of the injured worker's insomnia have been evaluated. Additionally, evidence based guidelines do not support the chronic use of sleep aids. In most instances, the recommendation is for 2-3 weeks of use until the normalization of sleep and then subsequent discontinuation of the medication.

Keratek Gel 4oz with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-114.

Decision rationale: The request for Keratek gel 4 ounces with 3 refills is not supported as medically necessary. The submitted clinical records provide no data as to where the injured worker is to apply this gel. Further, the serial records provide no data to establish that this topical analgesic is efficacious for the injured worker. There is no data that suggests that this reduces her pain levels.

Flurbiprofen/ Ranitidine 100mg/100mg #90 with 3 refills: 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): 67-73.

Decision rationale: The request for Flurbiprofen/Ranitidine 100/100 #90 with 3 refills is not supported as medically necessary. The submitted clinical records indicate that the injured worker has chronic pain associated with a lumbar strain and lumbar degenerative disease. The record provides no information regarding the efficacy of this medication. The records do not contain serial VAS scores indicating a reduction in pain levels as a result. As such, the medical necessity for the continuation of this medication has not been established.

Tizanidine 5mg #60 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: The request for Tizanidine 5mg #60 with 3 refills is not supported as medically necessary. The most recent physical examination notes that the injured worker is tender over L5 centrally. There is no indication of lumbar myospasms on physical examination establishing the medical necessity of this medication. Therefore, given the absence of spasms documented on physical examination, the continued use of this medication is not supported.