

Case Number:	CM14-0135310		
Date Assigned:	09/12/2014	Date of Injury:	02/01/1996
Decision Date:	10/06/2014	UR Denial Date:	08/11/2014
Priority:	Standard	Application Received:	08/22/2014

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 Physical Medicine and Rehabilitation 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:

This 63-year-old patient sustained an injury on 2/1/1996 while employed by [REDACTED] [REDACTED]. Request(s) under consideration include Lunesta 3mg #30 and Intrathecal Morphine Pump. Diagnoses include s/p remote L3-S1 fusion and left SI fusion with subsequent hardware removal and SCS implantation. Review indicated the patient has been treating for this 1996 injury for ongoing chronic low back radicular pain with Coccydynia rated at 10/10 without and 7/10 with medications. A spinal cord stimulator was placed in 2005 which gave 30-40% relief; however, none for axial low back amounts of oral analgesics. Side effects reported increased somnolence, suffered a fall at home sustaining rib fracture. Current request include trial of Intrathecal pain pump due to patient's debilitating pain and increasing usage of medications. The request(s) for Lunesta 3mg #30 and Intrathecal Morphine Pump were non-certified on 8/11/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

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, Mental Illness & Stress

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Insomnia Treatment Page(s): 535-536. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Insomnia Treatment, pages 535-536

Decision rationale: Per the Official Disability Guidelines (ODG), "Pain". Additionally, Lunesta is a non-benzodiazepine-like, Schedule IV controlled substance. Long-term use is not recommended as efficacy is unproven with a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic use is the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. Submitted documents have not demonstrated any functional improvement from Lunesta treatment prescribed for quite some time for this 1996 injury. Lunesta 3mg #30 is not medically necessary.

Intrathecal Morphine Pump: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Implantable drug-delivery systems (IDDSs) Page(s): 52-54.

Decision rationale: Guidelines recommend implantable drug-delivery systems (IDDS) only as a last resort in the treatment continuum of selected cases of chronic, severe failed back syndrome when no other therapies or effective management is left for the chronic intractable pain and should be used as part of a functional restoration program to facilitate return to activity and not just for pain reduction. The specific criteria include documented failure of all conservative treatment including oral medications, interventional pain modalities for clear objective pathology without psychological origin or further surgical intervention planned. Hence, indication for IDDS includes primary or metastatic liver, colorectal or head/neck cancers, severe refractory spasticity from cerebral or spinal cord injuries/lesion, none of which is demonstrated here. There is no documented specific confirmed pathology, psychological evaluation or failed trial of conservative care with medications and therapy to support this permanent pain pump placement outside guidelines criteria. Additionally, guidelines states trial must result in 50-70% reduction of pain with documented functional improvement and associated reduction in oral pain medications not demonstrated here with failed Intrathecal morphine pump trial in January and continued to report severe symptoms with unchanged function. The Intrathecal Morphine Pump is not medically necessary.