

<b>Case Number:</b>	CM14-0153676		
<b>Date Assigned:</b>	09/23/2014	<b>Date of Injury:</b>	08/29/1997
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	08/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/19/2014

### 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 & Rehabilitation, has a subspecialty in Pain Management 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 48-year-old female who reported an injury on 08/29/1997. The mechanism of injury involved heavy lifting. The current diagnoses include recurrent major depressive episodes, anxiety, depressive disorder, and lumbar postlaminectomy syndrome. Previous conservative treatment is noted to include medications, psychotherapy, physical therapy, home exercise, a Functional Restoration Program, acupuncture, injections, bracing, and weight loss. The current medication regimen includes Ibuprofen 800 mg, Lidoderm 5% patch, Lunesta 2 mg, Lyrica 25 mg, Suboxone 2 mg, Tylenol 500 mg, and Zanaflex 4 mg. The injured worker was evaluated on 08/12/2014 with complaints of chronic lower back pain with left lower extremity pain. Physical examination revealed an antalgic gait. Treatment recommendation at that time included continuation of the current medication regimen. A Request for Authorization form was then submitted on 08/14/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Zanaflex 4mg #600:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (For Pain) Page(s): 64-66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

**Decision rationale:** California MTUS Guidelines state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations. There was no documentation of palpable muscle spasm or spasticity upon physical examination. There was also no frequency listed in the request. As such, the request is not medically necessary.

**Suboxone 2mg-0.5mg #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine Page(s): 27-28.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 26-27.

**Decision rationale:** The California MTUS Guidelines recommend buprenorphine for treatment of opiate addiction. It is also recommended as an option for chronic pain after detoxification in patients who have a history of opiate addiction. As per the documentation submitted, the injured worker has continuously utilized this medication since 02/2014. There is no documentation of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.

**Tylenol extra strength 500mg #480:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 11-12.

**Decision rationale:** California MTUS Guidelines recommend acetaminophen for treatment of chronic pain and acute exacerbations of chronic pain. The injured worker has continuously utilized this medication since 02/2014 without any evidence of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.

**Lunesta 2mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 or sleep disorder. There is also no documentation of objective functional improvement despite the ongoing use of this medication since 02/2014. There is also no frequency listed in the request. As such, the request is not medically necessary.