

Case Number:	CM15-0004150		
Date Assigned:	01/15/2015	Date of Injury:	06/26/2003
Decision Date:	03/20/2015	UR Denial Date:	12/16/2014
Priority:	Standard	Application Received:	01/08/2015

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, New York, Florida

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease, Critical Care 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 59-year-old female who reported an injury on 08/26/2003. The mechanism of injury was the injured worker was trying to turn a beverage cart around. The diagnostic studies were noted to include an MRI of the lumbar spine which revealed postoperative changes of the lumbar fusion at L4-5. Other therapies were not provided. The injured worker underwent a bilateral L4-5 complete facetectomy, lateral recess decompression, complete and radical discectomy, placement of interbody cages, and L4-5 screw fixation on 12/17/2012. Medications were noted to include Lunesta, Flexeril, tramadol, and Cymbalta. The most recent documentation submitted for review per the treating physician requesting the medications was dated 10/27/2014. The documentation indicated the injured worker had no change and the injured worker was noted to have increased low back pain and discomfort when bending. The injured worker had a positive straight leg raise and increased symptoms. The diagnosis was lumbar herniated nucleus pulposus. The treatment plan included physical therapy 2x6 weeks, Lunesta 3 mg 1 by mouth at bedtime #30, Flexeril 10 mg 1 by mouth 3 times a day #90, tramadol 50 mg 1 by mouth every 4 to 6 hours, and Cymbalta 20 mg 1 by mouth 3 times a day. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 tablets of Lunesta 3mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2014, Pain Chapter, Lunesta

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, Lunesta.

Decision rationale: The Official Disability Guidelines indicate that Lunesta is recommended for short term use. The clinical documentation submitted for review indicated the injured worker had utilized the medication previously. There was a lack of documentation of objective functional benefit. The request as submitted failed to indicate the frequency for the requested medication. Given the above and the lack of documented efficacy, the request for 30 tablets of Lunesta 3 mg is not medically necessary.

90 tablets of Flexeril 10mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend muscle relaxants as a second line option for short term treatment of acute low back pain. Their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review failed to provide the duration of use; however, it was noted to be a medication that was to be refilled. There was a lack of documented efficacy for the requested medication. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for 90 tablets of Flexeril 10 mg is not medically necessary.