

Case Number:	CM15-0102937		
Date Assigned:	06/05/2015	Date of Injury:	06/05/2003
Decision Date:	07/10/2015	UR Denial Date:	05/20/2015
Priority:	Standard	Application Received:	05/28/2015

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 53 year old male who reported an industrial injury on 6/5/2003. His diagnoses, and/or impressions, are noted to include: status-post electrical shock; burns on the right hand; heart palpitations; strain/sprain of the cervical spine and cervical disc disease; headaches; status-post left shoulder decompression, debridement and bursectomy surgery; status-post right carpal tunnel release and ulnar nerve release; status-post excision hematoma of the right arm; subluxing left ulnar nerve; status-post incision and drainage of the left elbow from post-operative Methicillin Resistant Staff Aureus infection; status-post lumbar discectomy and fusion with instrumentation; post surgery lumbar burst fracture; status-post lumbar revision surgery and removal of hardware; and right medical meniscus tear. Current magnetic imaging studies of the lumbar spine were stated to be scheduled for 5/13/2015. His treatments have included surgeries; medication management with urine drug screenings; and rest from work. The progress notes of 5/12/2015 reported moderate-severe, radiating low back pain, with burning, to both legs, left > right; and improvement of pain with function from his current medications. Objective findings were noted to include a slight decrease in grip strength on the right; tenderness with spasms and tightness over the lower and left upper lumbar spine; decreased lumbar spine range-of-motion; and a decrease in sensation at the lumbar 5 nerve root. The physician's requests for treatments were noted to include the continuation of Lunesta, Lyrica, Zanaflex, Percocet and a urine drug screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

UDS Performed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 43.

Decision rationale: The MTUS recommends using a urine drug screen to assess for the use or the presence of illegal drugs, a step to take before a therapeutic trial of opioids, to aid in the ongoing management of opioids, or to detect dependence and addiction. There is no documentation in the medical record that a urine drug screen was to be used for any of the above indications. UDS Performed is not medically necessary.

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 (ODG), Mental Illness and Stress Chapter, Eszopicolone (Lunesta).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Insomnia treatment.

Decision rationale: The Official Disability Guidelines do not recommend the long-term use of any class of sleep aid. The patient has been taking Lunesta longer than the maximum recommended time of 4 weeks. The patient had not noted any functional improvement with the continued use of Lunesta. Lunesta 3mg, #30 is not medically necessary.

Lyrica 75mg #60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 19-20.

Decision rationale: The MTUS states that Lyrica has FDA approval for painful diabetic neuropathy, postherpetic neuralgia, and fibromyalgia. The patient is not diagnosed with the above indications. In addition, a recent review has indicated that there is insufficient evidence to recommend for or against antiepileptic drugs for axial low back pain. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly. Lyrica 75mg #60 with 1 refill is not medically necessary.

Zanaflex 4mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 63.

Decision rationale: Zanaflex is a drug that is used as a muscle relaxant. The MTUS states that muscle relaxants are recommended with caution only on a short-term basis. The patient has been taking the muscle relaxant for longer than the 2-3 week recommendation by the MTUS. Zanaflex 4mg #60 is not medically necessary.

Percocet 10/325mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-going Management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 74-94.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of Percocet, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. Percocet 10/325mg, #90 is not medically necessary.