

Case Number:	CM15-0131632		
Date Assigned:	07/17/2015	Date of Injury:	11/27/2000
Decision Date:	08/13/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	07/07/2015

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: Emergency 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 (IW) is a 71-year-old male who sustained an industrial injury on 11/27/2000. Diagnoses include status post anterior/posterior fusion at L4-5, L5-S1 with hardware removal; rule out herniated nucleus pulposus; bilateral lower extremity radiculopathy; and sleep disturbance/insomnia. Treatment to date has included medication, spinal fusion and subsequent hardware removal and epidural steroid injections (ESI). Medications and ESIs were helpful; ESIs were most helpful for radicular symptoms. According to the progress notes dated 5/29/15, the IW reported increased low back pain with bilateral lower extremity numbness and tingling. His pain was rated 9/10. On examination, his posture was slumped and he had difficulty rising from a seated position. His gait was antalgic and movement was stiff. There was tenderness to palpation over the lower back and sacrum with spasms left and right of the midline. Range of motion of the lumbar spine was diminished and painful. Motor testing of the lower extremities was grossly normal. Straight leg raise was negative bilaterally. The provider documented that the IW had received several lumbar spine injections with mild relief since the previous MRI and he was concerned about the risk of herniated nucleus pulposus. It is unclear when the last MRI was performed although a progress note dated 5/2/15 mentions it was done sometime in 2013. A progress note dated 3/4/15 mentions the results but the official report was not provided for review. The previous MRI of the lumbar spine showed multilevel disc protrusions and evidence of the prior fusion. A request was made for a lumbar spine MRI with and without gadolinium to rule out herniated nucleus pulposus (HNP); Ultracet 37.5mg, #120 for pain; and Lunesta 2mg, #30 for insomnia.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar MRI with and without gadolinium: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304, 309.

Decision rationale: As per ACOEM Guidelines, imaging studies should be ordered in event of "red flag" signs of symptoms, signs of new neurologic dysfunction, clarification of anatomy prior to invasive procedure or failure to progress in therapy program. Patient does not meet any of these criteria. There is no documented red flag findings in complaints or exam. There is no noted new neurologic dysfunction. Patient's pain is chronic and unchanged. The only rationale found for requested test was because the MRI was 2 years old and was to "rule out" herniated nucleus pulposus which is redundant because the prior MRI reported showed a herniated disc already. MRI of lumbar spine is not medically necessary.

Ultracet 37.5mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-79.

Decision rationale: Ultracet contains acetaminophen and Tramadol, a Mu-agonist, an opioid-like medication. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation fails criteria. Provider has not documented any benefit from medications with continued severe pain and poor function. There is no long-term plan documented concerning pain management therapy. Ultracet is not medically necessary.

Lunesta 2mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain Chapter (updated 4/30/15).

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

Decision rationale: There is no specific sections in the MTUS chronic pain or ACOEM guidelines that relate to this topic. Lunesta is a benzodiazepine agonist approved for insomnia. As per ODG guidelines, it recommends treatment of underlying cause of sleep disturbance and recommend short course of treatment. Long-term use may lead to dependency. Patient has been on Lunesta chronically. While Lunesta has been approved for longer term use by FDA, long term use is still not recommended. There is no documentation of other conservative attempts at treatment of sleep disturbance or sleep studies. The prescription is excessive and not consistent with short-term use or attempts to wean patient off medication. The chronic use of Lunesta is not medically appropriate and is not medically necessary.