

Case Number:	CM15-0143681		
Date Assigned:	08/04/2015	Date of Injury:	09/05/2007
Decision Date:	09/22/2015	UR Denial Date:	07/16/2015
Priority:	Standard	Application Received:	07/24/2015

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: Texas, Illinois

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 52-year-old female who sustained an industrial injury on 9-5-2007. She injured herself while holding a child when she twisted her body and felt immediate pain to her neck and back. She has report neck and back complaints and has been diagnosed with lumbar radiculopathy, lumbar herniated disc, lumbar spinal stenosis, lumbar spondylosis without myelopathy, lumbar degenerative disc disease, and lumbago. Treatment has included injections, physical therapy, acupuncture, and medications. There was tenderness to palpation along bilateral mid to lower lumbar paraspinal muscles and along bilateral sacroiliac joints; full, active, active lumbar flexion. Seated straight leg raise test was positive bilaterally. The treatment plan included medications and a urine drug screen. The treatment request included a urine drug screen and quantitative urine confirmation, cyclobenzaprine, eszopiclone, CM3 Ketoprofen, and Percocet.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine drug screen and quantitative confirmation (Retrospective): Upheld

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

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) Urine drug testing (UDT).

Decision rationale: The injured worker sustained a work related injury on 9-5-2007. The medical records provided indicate the diagnosis of lumbar radiculopathy, lumbar herniated disc, lumbar spinal stenosis, lumbar spondylosis without myelopathy, lumbar degenerative disc disease, and lumbago. Treatment has included injections, physical therapy, acupuncture, and medications. The medical records provided for review do not indicate a medical necessity for Urine drug screen and quantitative confirmation (Retrospective) The Official Disability Guidelines recommends confirmatory testing is done in contested results, but there is no indication the screening test result is being contested in this case. The MTUS is silent on confirmatory drug testing. The Official Disability Guidelines states as follows: These tests are particularly important when results of a test are contested. When to perform confirmation: When the POC screen is appropriate for the prescribed drugs without evidence of non-prescribed substances, confirmation is generally not required. Confirmation should be sought for (1) all samples testing negative for prescribed drugs, (2) all samples positive for non-prescribed opioids, and (3) all samples positive for illicit drug.

Cyclobenzaprine 7.5mg #60 with no refills: 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 Muscle relaxants (for pain) Page(s): 63-64.

Decision rationale: The injured worker sustained a work related injury on 9-5-2007. The medical records provided indicate the diagnosis of lumbar radiculopathy, lumbar herniated disc, lumbar spinal stenosis, lumbar spondylosis without myelopathy, lumbar degenerative disc disease, and lumbago. Treatment has included injections, physical therapy, acupuncture, and medications. The medical records provided for review do not indicate a medical necessity for Cyclobenzaprine 7.5mg #60 with no refills. Cyclobenzaprine (Flexeril), is a muscle relaxant. The MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic Low back pain. The recommended dosing of Cyclobenzaprine is 5-10 mg three times a day for no longer than 2-3 weeks. The records indicate she has used this for some time; therefore, the requested treatment is not medically necessary.

Eszopiclone 2mg #30 with no refills: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Eszopiclone (Lunesta).

Decision rationale: The injured worker sustained a work related injury on 9-5-2007. The medical records provided indicate the diagnosis of lumbar radiculopathy, lumbar herniated disc, lumbar spinal stenosis, lumbar spondylosis without myelopathy, lumbar degenerative disc disease, and lumbago. Treatment has included injections, physical therapy, acupuncture, and medications. The medical records provided for review do not indicate a medical necessity for Eszopiclone 2mg #30 with no refills. Eszopiclone (Lunesta) is a hypnotic used for the short treatment of insomnia. The MTUS is silent on it, but the Official Disability Guidelines recommend limiting use of hypnotics to three weeks maximum in the first two months of injury only, and discourage use in the chronic phase. The medical records indicate she has used this medication for at least one month; therefore the requested treatment is not medically necessary.

CM3 Ketoprofen 20% 1 tube with no refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The injured worker sustained a work related injury on 9-5-2007. The medical records provided indicate the diagnosis of lumbar radiculopathy, lumbar herniated disc, lumbar spinal stenosis, lumbar spondylosis without myelopathy, lumbar degenerative disc disease, and lumbago. Treatment has included injections, physical therapy, acupuncture, and medications. The medical records provided for review do not indicate a medical necessity for CM3 Ketoprofen 20% 1 tube with no refills. The topical analgesics are largely experimental drugs primarily used in the treatment of neuropathic pain that has failed treatment with antidepressants and anticonvulsants. The MTUS states that any compounded product that contains at least one drug (or drug class) that is not recommended. Ketoprofen is an NSAID, and it is not recommended as a topical analgesic; besides the injured worker is still being treated with antidepressants.

Percocet 10/325mg #90 with no refills: 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 Opioids Page(s): 78-81.

Decision rationale: The injured worker sustained a work related injury on 9-5-2007. The medical records provided indicate the diagnosis of lumbar radiculopathy, lumbar herniated disc, lumbar spinal stenosis, lumbar spondylosis without myelopathy, lumbar degenerative disc disease, and lumbago. Treatment has included injections, physical therapy, acupuncture, and medications. The medical records provided for review do not indicate a medical necessity for Percocet 10/325mg #90 with no refills. Percocet is the brand name of the opioid, Oxycodone, and acetaminophen. The MTUS recommends the use of the lowest dose of opioids for the short

term treatment of moderate to severe pain. The MTUS does not recommend the long term use of opioids in the treatment of chronic pain due to worsening adverse effects and lack of research in support of benefit. Also, the MTUS recommends that individuals on opioid maintenance treatment be monitored for analgesia (pain control), activities of daily living, adverse effects and aberrant behavior; the MTUS recommends discontinuation of opioid treatment if there is no documented evidence of overall improvement or if there is evidence of illegal activity or drug abuse or adverse effect with the opioid medication. The medical records indicate she has been on this medication at least for one month, on other opioids at least since 01/2015, but with no overall improvement. The pain seems to be getting worse, requiring hospitalization.