

Case Number:	CM15-0036671		
Date Assigned:	03/05/2015	Date of Injury:	11/04/2012
Decision Date:	04/21/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	02/26/2015

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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 44-year-old female who reported injury on 11/04/2012. The diagnosis was lumbago. The mechanism of injury was not provided. The documentation of 01/07/2015 revealed the injured worker had complaints of constant pain in the low back aggravated by bending, twisting, lifting, pushing, pulling, prolonged sitting, prolonged standing, and walking multiple blocks. The pain was a 7 on a scale of 1 to 10. There was palpable paravertebral muscle tenderness with spasms. The seated nerve root test was positive. Standing flexion and extension were guarded and restricted. The injured worker had tingling and numbness in the lateral thigh, anterolateral thigh, leg and foot, anterior knee, medial leg and foot correlating with L4-5 dermatomal patterns. There was decreased strength of 4/5 in the quadriceps and EHL, which are L4, and L5 innervated muscles. The diagnoses included status post left L4-5 hemilaminotomy and microdiscectomy with neural decompression and recurrent disc herniation. Treatment plan included medications. The documentation indicated the injured worker would be prescribed Fenoprofen calcium 400 mg #120, omeprazole DR 20 mg for GI symptoms, Ondansetron 8 mg for nausea associated with headaches that are present due to chronic cervical spine pain, cyclobenzaprine for palpable muscle spasms, tramadol for acute severe pain, and Lunesta for temporary insomnia. The injured worker was noted to be utilizing the medications since at least 09/2014. There was a request for authorization submitted for review dated 01/22/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20 mg Qty 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend PPIs for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review indicated the injured worker was being given the medication for dyspepsia symptoms. However, there was a lack of documented efficacy as the injured worker had utilized the medication for an extended duration of time. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for omeprazole 20 mg #120 is not medically necessary.

Cyclobenzaprine 7.5 mg Qty 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

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 the 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 documentation of objective functional improvement. The documentation indicated the injured worker had utilized the medication for an extended duration of time. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for cyclobenzaprine 7.5 mg Qty 120 is not medically necessary.

Tramadol 150 mg Qty 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, and objective decrease in pain and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of objective functional improvement, an objective decrease in pain and documentation the injured worker was being monitored for aberrant drug behavior. The injured worker was being monitored for side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for tramadol 150 mg Qty 90 is not medically necessary.

Eszopiclone 1 mg Qty 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, Mental Illness & Stress; Psychotherapy Guidelines.

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, Eszopiclone.

Decision rationale: The Official Disability Guidelines indicate that Eszopiclone is recommended for the short-term treatment of insomnia. The documentation indicated the injured worker had utilized the medication since at least 09/2014. The efficacy was not provided. There is a lack of documentation of exceptional factors to warrant further usage. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Eszopiclone 1 mg Qty 30 is not medically necessary.