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| <b>Case Number:</b>   | CM15-0058940 |                              |            |
| <b>Date Assigned:</b> | 04/03/2015   | <b>Date of Injury:</b>       | 06/17/1995 |
| <b>Decision Date:</b> | 05/22/2015   | <b>UR Denial Date:</b>       | 03/13/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 03/27/2015 |

### 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, Public Health & General Preventive 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 64-year-old female. The mechanism of injury was not provided. The date of injury was not provided. The documentation of 02/26/2015 revealed the injured worker had a primary complaint of left leg pain greater than right and low back pain. The physician documentation indicated the injured worker's pain was stable and there was a request for a refill of medications. The injured worker was utilizing them appropriately without cognitive deficits. The injured worker was given 3 prescriptions of morphine ER and 2 of MSIR. The injured worker was CURES appropriate. The pain rating was a 9 at worst and initially was a 6. The pain was constant. MSER 60 mg 1 by mouth twice a day was prescribed and MSIR 30 mg 1 by mouth twice a day was prescribed. There was no other physician documentation submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Baclofen 10mg #120x 3 months:** Upheld

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

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

**Decision rationale:** The California MTUS guidelines recommend muscle relaxants as a second line option for the short-term treatment of acute low back pain, less than 3 weeks and there should be documentation of objective functional improvement. The clinical documentation submitted for review failed to provide documentation of objective functional improvement. There was a lack of documented rationale for a necessity for 3 months of muscle relaxant without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for baclofen 10 mg #120 x3 months is not medically necessary.

**Dexilant 60mg #30x 3 months:** Upheld

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

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

**Decision rationale:** The California MTUS guidelines recommend proton pump inhibitors for injured workers at intermediate risk or higher for gastrointestinal events and are also for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review failed to provide the injured worker had complaints of dyspepsia. There was a lack of documented rationale for the requested 3 months of Dexilant. The efficacy was not provided. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Dexilant 60 mg #30 x3 months is not medically necessary.

**Lorazepam 1mg #20 x3 months:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** The California MTUS Guidelines do not recommend the use of benzodiazepines for longer than 4 weeks due to the possibility of psychological or physiological dependence. The clinical documentation submitted for review failed to provide the duration of use for the requested medication. The rationale was not provided. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documented rationale indicating a necessity for 3 months of benzodiazepine. Given the above, the request for lorazepam 1 mg #20 x3 months is not medically necessary.

**Lunesta 3mg #20:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [HTTP://www.odg-twc.com](http://www.odg-twc.com).

**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 the short term treatment of insomnia. The duration of use could not be established. The efficacy of the medication could not be established. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Lunesta 3 mg #20 is not medically necessary.

**Labs: TSH, T3, T4, VIT D, CBC, CMP, Fasting Lipids:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 70. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&query=laboratory+tests>.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines indicate that the package inserts for NSAIDs recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests). There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy, but the interval of repeating lab tests after this treatment duration has not been established. They do not, however, address TSH, T3, T4, and VIT D. Per [nlm.nih.gov](http://nlm.nih.gov), Laboratory tests check a sample of your blood, urine, or body tissues. Laboratory tests are often part of a routine checkup to look for changes in your health. They also help doctors diagnose medical conditions, plan or evaluate treatments, and monitor diseases. There was a lack of documented rationale for the requested laboratory studies. Given the above and the lack of documentation, the request for Labs: TSH, T3, T4, VIT D, CBC, CMP, Fasting Lipids is not medically necessary.