

<b>Case Number:</b>	CM15-0013692		
<b>Date Assigned:</b>	02/02/2015	<b>Date of Injury:</b>	04/21/2011
<b>Decision Date:</b>	03/19/2015	<b>UR Denial Date:</b>	01/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/23/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 53 year old male sustained an industrial injury on 4/24/11, with subsequent ongoing back and right hip pain. The injured worker underwent right hip arthroscopic surgery on 10/9/12. Magnetic resonance imaging lumbar spine (2011) showed disc complex at L5-S1 with mild spinal stenosis and annular tear. EMG right lower extremity (2/20/13) was normal. In a PR-2 dated 12/30/14, the injured worker complained of a two month history of a flare up of right hip pain that interfered with sleep. The injured worker was sleeping approximately two hours per night. Medications relieved the pain over 50% from 8-9/10 on the visual analog scale to 4/10, allowing him to safely active and functional at home. Physical exam was remarkable for pain with abduction of the right hip and positive FABER's maneuver. Current diagnoses included chronic right hip joint pain and chronic low back pain. Work status was retired. The treatment plan included continuing medications (Percocet, Morphine Sulfate and Neurontin), replacing Ambien with Lunesta to assist with sleep difficulties, x-ray of the right hip and continuing with physical therapy. On 1/15/15, Utilization Review noncertified a request for UA drug screen and Lunesta 3 mg #30, noting lack of aberrant behavior and two previous drug screens within the year and citing CA MTUS Chronic Pain Medical Treatment Guidelines and ODG Guidelines. As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**UA drug screen:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG, Pain Chapter, Urine drug testing (UDT)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-84.

**Decision rationale:** The request is for a urine specimen toxicology screen. The California MTUS does recommend urine drug screens for patients on opioid therapy, The following are steps to avoid misuse of opioids, and in particular, for those at high risk of abuse:a) Opioid therapy contracts. See Guidelines for Pain Treatment Agreement.b) Limitation of prescribing and filling of prescriptions to one pharmacy.c) Frequent random urine toxicology screens.The included progress notes do indicate the patient is on chronic opioid therapy in the form of Morphine and Percocet. Periodic and random drug screening is recommended in patient?s who are on opioid therapy per the California MTUS. Therefore criteria for a urine drug screen have been met and the request is certified.

**Lunesta 3mg #30:** Overturned

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation insomnia

**Decision rationale:** The California MTUS and the ACOEM do not specifically address this medication. Per the official disability guidelines recommend pharmacological agents for insomnia only is used after careful evaluation of potential causes of sleep disturbance. Primary insomnia is usually addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. Pharmacological treatment consists of four main categories: Benzodiazepines, Non-benzodiazepines, Melatonin and melatonin receptor agonists and over the counter medications. Sedating antidepressants have also been used to treat insomnia however there is less evidence to support their use for insomnia, but they may be an option inpatients with coexisting depression. The patient does have the diagnosis of insomnia. The requested medication does treat insomnia and falls within the recommended categories per the ODG. Therefore the request is certified.