

<b>Case Number:</b>	CM15-0063248		
<b>Date Assigned:</b>	04/09/2015	<b>Date of Injury:</b>	11/05/1990
<b>Decision Date:</b>	05/28/2015	<b>UR Denial Date:</b>	03/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2015

### 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: New York  
 Certification(s)/Specialty: Anesthesiology

### 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 55 year old male patient who sustained an industrial injury on 11/05/1990. A primary treating office visit dated 01/14/2013 reported the patient taking Mobic, Prilosec, Ultram, Ambien, and Vicodin. He is not attending therapy. He is utilizing a transcutaneous nerve stimulating (TENS) unit every day at home. He is not working. There is subjective complaint of constant low back pain accompanied with numbness to the back of bilateral legs. The following diagnoses are applied: musculoligamentous sprain of the lumbar spine; disc bulge L4-5, and left leg radiculitis. The plan of care involved prescribing refills of current medications, continue using TENS, and return for follow up in 5-6 months. The most recent primary treating office visit dated 02/16/2015 reported subjective complaint of low back pain is constant and is more stabbing now. He reports taking Flurbiprofen/Omeprazole. He states he uses a cane for stability. The plan of care involved prescribing Eszopiclone, Flurbiprofen/Omeprazole, and Tramadol. He was administered an injection in the upper arm treating low back pains. He is to follow up in 5-6 months.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Eszopiclone 1 mg #90 with 3 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), Eszopiclone (Lunesta), pain, insomnia treatment: mental illness and stress.

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

**Decision rationale:** Eszopiclone (Lunesta) is a prescription short-acting non-benzodiazepine sedative-hypnotic, which is recommended for short-term treatment of insomnia (two to six weeks). Lunesta is indicated for the treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. According to the ODG guidelines, non-Benzodiazepine sedative-hypnotics are considered first-line medications for insomnia. It appears that the non-benzodiazepines have similar efficacy to the benzodiazepines with fewer side effects and short duration of action. Eszopiclone has demonstrated reduced sleep latency and sleep maintenance. It is recommended for short-term use. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. In this case, there is no documentation that the patient has had a history of insomnia or sleep disturbances. Medical necessity of the requested medication with 3 refills has not been established. The requested medication is not medically necessary.

**Flurbiprofen/Ome100 mg/10 mg #60 with 3 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms, and cardiovascular risk Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-pain chapter, compound drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs PPIs Page(s): 67-71. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs PPIs.

**Decision rationale:** The requested medication is a combination of a non-steroidal anti-inflammatory drug (NSAID) and a proton pump inhibitor (PPI). Flurbiprofen, an oral NSAID, is recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. The ODG states that NSAIDs are recommended for acute pain, osteoarthritis, acute low back pain (LBP) and acute exacerbations of chronic pain, short-term pain relief in chronic LBP, and short-term improvement of function in chronic LBP. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain. Guidelines recommended that the lowest effective dose be used for the shortest duration of time consistent with treatment goals. According to the California MTUS, Omeprazole (Prilosec), is proton pump inhibitor (PPI) that is recommended for patients taking NSAIDs, with documented GI distress symptoms, or at risk for gastrointestinal events. GI risk factors include: age >65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants, or high dose/multiple NSAIDs. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. There is no documentation indicating that this patient had any GI symptoms or risk factors. In this case, the patient had prior use of NSAIDs

without any documentation of significant improvement. There was no documentation of objective benefit from use of this medication. Medical necessity of the requested combination medication has not been established. The request for Flurbiprofen/ Omeprazole is not medically necessary.

**Tramadol/Acetaminophen/Ondansetron 50 mg/250/2 mg #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids, on-going management Page(s): 78. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-compound drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain.

**Decision rationale:** The requested medication is a combination of an opioid analgesic, an analgesic, and an anti-emetic. According to the California MTUS, Tramadol (Ultram) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, there has been no documentation of the medication's analgesic effectiveness or functional improvement. There was no documentation to indicate that GI symptoms have been limiting the use of a narcotic analgesic. Importantly, Ondansetron is not used and is ineffective for nausea associated with narcotic analgesics. Medical necessity of the requested combination medication has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested combination medication is not medically necessary.

**Retrospective Ketorolac 60 mg with Zylocaine 1 ml administered: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 72.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs, Ketorolac.

**Decision rationale:** Ketorolac (Toradol) is a non-steroidal anti-inflammatory drug (NSAID). The oral form is only recommended for short-term (up to 5 days) management of moderately severe acute pain that requires analgesia at the opioid level, and only as continuation following IV or IM dosing, if necessary. This medication is not indicated for minor or chronic painful conditions. It is also unclear if the Toradol administration requested is for IV or IM injection (with Lidocaine 1ml). Medical necessity for the retrospective medication was not been established. The requested medication was not medically necessary.

