

<b>Case Number:</b>	CM13-0036741		
<b>Date Assigned:</b>	04/25/2014	<b>Date of Injury:</b>	07/12/2011
<b>Decision Date:</b>	06/02/2014	<b>UR Denial Date:</b>	09/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/22/2013

### 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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management, and is licensed to practice in Florida. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 an unknown age male who reported an injury reported on September 19, 2013. The injured worker has a diagnosis of displacement of lumbar intervertebral disc without myelopathy as documented on the State of California Department of Industrial Relations Division of Workers' Compensation Application for Independent Medical Review. A modified provider letter found in the notes reports that a progress note from [REDACTED] on August 12, 2013 reported subjective complaints of persistent pain in his head and back along with hair loss and vision difficulties. The exam findings are documented in this modified letter as paralumbar tenderness and spasm, decreased lumbar motion, positive straight leg raising bilaterally and diminished sensation at the S1 nerve root distribution with range of motion findings of flexion to 30 degrees with pain, extension to 0 degrees, bilaterally positive straight leg raising and diminished sensation at the S1 nerve root distribution. The diagnoses were noted as thoracic and lumbar disc herniation, radiculitis bilateral lower extremities, chronic headaches post injury, hair loss and vision disturbances. Work status was temporary total disability with a treatment plan to use medications. The documentation submitted for review does not contain a request for authorization.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TRAMADOL ER 150MG #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-77.

**Decision rationale:** The request for Tramadol ER 150mg is non-certified. The documentation submitted for review does not indicate the use of non-opioid analgesics, it fails to indicate if the pain is moderate to severe thus indicating a need for opioid treatment. The Chronic Pain Medical Treatment Guidelines for use of opioids indicate opioids are not recommended as a first-line therapy for some neuropathic pain. The guidelines indicate that a failed trial opioids should not be employed until the patient has failed a trial of non-opioid analgesics. The request for Tramadol ER 150 mg, sixty count, is not medically necessary or appropriate.

**CYCLOBENZAPINE 7.5MG #15:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASMODICS Page(s): 64.

**Decision rationale:** The request for Cyclobenzapine 7.5mg is non-certified. The injured worker has documentation of tenderness and spasm; however, Cyclobenzapine is only recommended for short term treatment starting at a dose of 5mg. According to the Chronic Pain Medical Treatment Guidelines the request exceeds the recommended dose and it should be considered only as a second line of treatment due to modest effect and high price of adverse effects. The request for Cyclobenzapine 7.5 mg, thirty count, is not medically necessary or appropriate.

**OMEPRAZOLE 20MG #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), GI (gastrointestinal) Page(s): 68.

**Decision rationale:** The request for Omeprazole 20mg is non-certified. The injured worker is not at risk of a gastrointestinal event based on the furnished documentation. The Chronic Pain Medical Treatment Guidelines indicate that a proton pump inhibitor is recommended only when the patient has current use of ASA or a high dose of NSAIDS, long term use of PPI's (proton pump inhibitors) carry risks. The request for Omeprazole 20 mg, thirty count, is not medically necessary or appropriate.

**DICLOFENAC XR 100MG #30:** Upheld

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

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

**Decision rationale:** The request for Diclofenac10%/Ketoprofen10%/Gabapentin10%/Lidocaine5% Cream is non-certified. The injured worker states tenderness; however, the Chronic Pain Medical Treatment Guidelines state that the compounded medications in this cream are extremely experimental and not recommended. Diclofenac has not been evaluated for treatment of the spine and Ketoprofen has an extremely high incidence of photocontact dermatitis. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The Chronic Pain Medical Treatment Guidelines also state Gabapentin is not recommended in topical form. The request for Diclofenac 10%/Ketoprofen 10%/Gabapentin 10%/Lidocaine 5% Cream is not medically necessary or appropriate.

**DICLOFENAC10%/KETOPROFEN10%/GABAPENTIN10%/LIDOCAINE5% CREAM:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Nonselective Nsaids Page(s): 71.

**Decision rationale:** The request for Diclofenac XR 100mg is non-certified. The documentation supported does not indicate conservative pain relievers have failed thus creating a need for Diclofenac. The Chronic Pain Medical Treatment Guidelines indicate that this medication has risks with long term use. Diclofenac is not recommended as first line due to increased risk profile. In addition, there were no clinical notes submitted for review. The request for Diclofenac XR 100 mg, thirty count, is not medically necessary or appropriate.