

<b>Case Number:</b>	CM13-0055264		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	06/12/2002
<b>Decision Date:</b>	04/30/2014	<b>UR Denial Date:</b>	10/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/21/2013

### 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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 a 43-year-old male who reported an injury on 06/12/2012. The mechanism of injury was not provided for review. The injured worker was evaluated on 10/03/2013. It was documented the injured worker's left lower leg had a well-healed scar over the medial aspect of the distal left lower extremity with 1+ edema. It was noted the injured worker had discoloration extending from the medial aspect of the ankle and foot to the mid portion of the left lower leg. It was noted there was no evidence of vascular insufficiency. The injured worker's diagnoses included status post phlebotic left lower leg, chronic venous insufficiency per history, prior history of deep vein thrombosis, and acute symptoms to lower leg with discoloration and edema. The injured worker's treatment plan included an ultrasound of the left lower extremity and continuation of medications to cure and relieve symptoms related to the industrial injury.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CYCLOBENZAPRINE 7.5MG #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

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

**Decision rationale:** The requested cyclobenzaprine 7.5 mg #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends short courses of treatment of muscle relaxants for acute exacerbations of chronic pain. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 10/2013. The clinical documentation fails to provide any evidence of functional benefit of this medication. Therefore, there are no exceptional factors to extend treatment beyond guideline recommendations. Additionally, the request as it is submitted does not include every frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the request for cyclobenzaprine 7.5 mg #90 is not medically necessary or appropriate.

**MENTHODERM 120ML:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SALICYLATE TOPICALS Page(s): 105.

**Decision rationale:** The requested Menthoderm 120 mL is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of salicylate topical medications in the management of chronic pain. However, the injured worker's most recent clinical evaluation does not provide any significant deficits that would support the need for this medication. Additionally, the request as it is submitted does not provide a duration, quantity, or frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Menthoderm 120 mL is not medically necessary or appropriate.

**OMEPRAZOLE 20MG #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 68.

**Decision rationale:** The requested omeprazole 20 mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the continued use of gastrointestinal protectants be supported by documentation and evaluation of the patient's gastrointestinal system to support that the patient is at risk for development of gastrointestinal events related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the patient's gastrointestinal system to support the use of this medication. Additionally, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested omeprazole 20 mg #60 is not medically necessary or appropriate.