

<b>Case Number:</b>	CM13-0056833		
<b>Date Assigned:</b>	06/09/2014	<b>Date of Injury:</b>	06/27/1988
<b>Decision Date:</b>	08/26/2014	<b>UR Denial Date:</b>	11/17/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/23/2013

### 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 Internal Medicine, Pulmonary Diseases and is licensed to practice in California. 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 52-year-old female who reported an injury on 06/27/1988 due to accumulative trauma while performing normal job duties. The injured worker's treatment history included physical therapy, medications, chiropractic care, and a home exercise program. The injured worker's most recent evaluation was on 02/27/2014. It was noted that the injured worker had low back pain complaints. Physical findings included tenderness to palpation of the cervical paraspinal musculature with painful range of motion and a positive impingement sign and Hawkin's sign, tenderness to palpation of the right shoulder with a positive impingement sign and Hawkin's sign and a limited range of motion secondary to pain, and tenderness to palpation of the lumbar spinous process with painful range of motion and a positive seated nerve root test. The injured worker's diagnoses included cervical discopathy and right shoulder impingement. The injured worker's treatment plan included chiropractic care and acupuncture. A request was made for a refill of medications. However, no justification for the request was provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PRESCRIPTION OF NAPROXEN 550MG, #100:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines for Chronic pain and NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 60 and 67.

**Decision rationale:** The prescription of naproxen 550mg, #100 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of naproxen as a first line medication in the management of chronic pain. The clinical documentation indicates that the injured worker has been taking this medication since at least 05/2013. However, the clinical documentation fails to provide any evidence of increased functional activity or pain relief resulting from the use of this medication. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested prescription of naproxen 550mg, #100 is not medically necessary or appropriate.

**PRESCRIPTION OF CYCLOBENZAPRINE 7.5MG, #120:** Upheld

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

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

**Decision rationale:** The requested prescription for cyclobenzaprine 7.5mg, #120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend muscle relaxants in the management of chronic pain. The use of muscle relaxants should be reserved for acute exacerbations of chronic pain and be limited to durations of treatment not to exceed 2 to 3 weeks. The clinical documentation does indicate that the injured worker has been on this medication since at least 05/2013. There are no exceptional factors noted within the documentation to support extending treatment beyond Guideline recommendations. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested prescription of cyclobenzaprine 7.5mg, #120 is not medically necessary or appropriate.

**PRESCRIPTION OF SUMATRIPTAN 25MG, #18:** 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), Head Chapter.

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

**Decision rationale:** The requested prescription of sumatriptan 25mg, #18 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this medication. Official Disability Guidelines recommend triptans to assist with migraine

control. The clinical documentation submitted for review indicates that the injured worker has been taking this medication since at least 05/2013. However, an adequate assessment of the injured worker's migraines was not provided to support continued use of this medication. There is no indication of frequency, strength, or duration of the injured worker's migraines. Therefore, the need to continue treatment is not established. Furthermore, the request as it is submitted does not include a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested prescription of sumatriptan 25mg, #18 is not medically necessary or appropriate.

#### **PRESCRIPTION OF ONDANSETRON ODT 8MG, #60: 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), Pain (Chronic).

**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, Anti-Emetics.

**Decision rationale:** The requested prescription of ondansetron ODT 8mg, #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines recommend this medication for acute gastritis. The clinical documentation submitted for review does not provide any evidence that the injured worker has had a sudden onset of acute gastritis that would benefit from this medication. Therefore, continued use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested prescription of ondansetron ODT 8mg, #60 is not medically necessary or appropriate.

#### **PRESCRIPTION OF OMEPRAZOLE DR 20MG, #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

**Decision rationale:** The requested prescription of omeprazole DR 20mg, #120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends gastrointestinal protectants for injured workers who are at risk for developing gastrointestinal events related to medication usage. The clinical documentation submitted for review did not provide an adequate assessment of the injured worker's gastrointestinal system to support that they are at risk for developing gastrointestinal events related to medication usage. Therefore, continued use would not be indicated in this clinical situation. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information,

the appropriateness of the request itself cannot be determined. As such, the requested prescription of omeprazole DR 20mg, #120 is not medically necessary or appropriate.

**PRESCRIPTION OF TRAMADOL ER 150MG, #90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

**Decision rationale:** The requested prescription of tramadol ER 150mg, #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by a quantitative assessment of pain relief, documented functional benefit, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker is monitored for aberrant behavior with urine drug screens. However, the clinical documentation fails to provide a quantitative assessment to support pain relief. Increased functional benefit related to medication usage is also not provided. Therefore, ongoing use of this medication would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested prescription of tramadol ER 150mg, #90 is not medically necessary or appropriate.