

<b>Case Number:</b>	CM13-0064050		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	11/28/2009
<b>Decision Date:</b>	04/15/2014	<b>UR Denial Date:</b>	11/20/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/11/2013

### 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 patient is a 65-year-old male who reported an injury on 11/28/2009. The mechanism of injury involved a fall. The patient is currently diagnosed with mild ligamentous strain of the lumbar spine with radicular symptoms, compression/contusion injury of the right shoulder, and status post arthroscopic surgery to the right shoulder in 2011. The patient was seen by [REDACTED] on 06/20/2013. The patient reported persistent pain in the lower back with radiation to the right lower extremity, as well as right shoulder pain. Physical examination revealed diminished range of motion of the bilateral shoulders, tenderness to palpation, a mildly antalgic gait, and decreased lumbosacral range of motion, positive straight leg raising, muscle spasm, and tenderness to palpation. Treatment recommendations included prescriptions for Omeprazole, Naproxen, Cyclobenzaprine, and Tramadol.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**60 NAPROXEN 550MG:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. There is no change in the patient's physical examination that would indicate functional improvement. The request for 60 Naproxen 550mg is not medically necessary and appropriate.

**60 OMEPRAZOLE 20MG:** Upheld

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

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

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. The request for 60 Omeprazole 20mg is not medically necessary and appropriate

**CYCLOBENZAPRINE 7.5MG:** Upheld

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

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

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations in patients with chronic low back pain. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. As per the documentation submitted, the patient has previously utilized this medication. Despite ongoing use, the patient continues to demonstrate palpable muscle spasm. The request for Cyclobenzaprine 7.5mg is not medically necessary and appropriate.

**60 TRAMADOL:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. There is no change in the patient's physical examination that would indicate functional improvement. The request for 60 Tramadol 50mg is not medically necessary and appropriate.