

Case Number:	CM13-0065676		
Date Assigned:	03/03/2014	Date of Injury:	10/17/2009
Decision Date:	05/27/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/13/2013

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 Orthopedic Surgery, 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 claimant is a 32-year-old who was injured on October 17, 2009. Current clinical record of October 10, 2013 with [REDACTED] indicated chief complaints of back and neck pain, bilateral shoulder and left knee pain noted to be "essentially unchanged". Physical examination findings showed cervical tenderness to paravertebral muscle palpation with pain to terminal motion. The shoulder examination was noted to be unchanged with pain and tenderness over the girdles with no instability and negative apprehension. Lumbar examination was with tenderness with range of motion and pain with terminal motion with positive seated straight leg raise and dysesthesias in an L5-S1 dermatomal distribution. There was a positive patellar grind test, negative anterior drawer, McMurray's testing and pain and tenderness noted about the left knee with palpation. Recommendations at that time were for continuation of medication management as well as intramuscular injections of Toradol and B12. Further clinical records are not noted. The claimant's working diagnoses on that visit were of cervical and lumbar discopathy with internal derangement to the bilateral shoulders and a left knee strain. Medications were to continue in the form of Naprosyn, tramadol, omeprazole and cyclobenzaprine.

IMR ISSUES, DECISIONS AND RATIONALES

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

CYCLOBENZAPRINE HYDROCHLORIDE TABLET 7.5 MG, 120 COUNT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 65.

Decision rationale: The Chronic Pain Medical Treatment Guidelines would not support the continued use of muscle relaxants. This individual is currently with no documentation of acute exacerbation with recent clinical complaints noted to be stable. Guidelines would not recommend the role of muscle relaxants except in situations as secondary agent for acute exacerbations in the chronic setting. Without documentation of an acute exacerbation, this medication would not be indicated in the chronic setting. The request for cyclobenzaprine hydrochloride tablet 7.5 mg, 120 count, is not medically necessary or appropriate.

OMEPRAZOLE DELAYED-RELEASE CAPSULE 20MG, 120 COUNT: 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) Symptoms & Cardiovascular.

Decision rationale: This individual fails to meet any evidence based Guideline criteria for GI risk factor for use of this protective proton pump inhibitor. Lack of documentation of a GI risk factor would not support the role of this agent for nonsteroidal medication induced gastritis. The request for omeprazole delayed-release capsule 20mg, 120 count, is not medically necessary or appropriate.

TRAMADOL HYDROCHLORIDE 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 Chronic Pain Section Page(s): 91-94.

Decision rationale: Recent literature indicates lack of efficacy of tramadol following sixteen weeks of use. This individual is currently being treated in the chronic setting with use of tramadol with no documentation of benefit at last clinical assessment. The continued role of this agent at this stage of the claimant's chronic course of care would not be supported. The request for tramadol hydrochloride er 150mg, ninety count, is not medically necessary or appropriate.

NAPROXEN SODIUM TABLET 550MG #100: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Section Page(s): 70-73.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommends the role of Naprosyn at the lowest dose possible at the shortest amount of time possible in the chronic setting. This individual's last clinical assessment failed to demonstrate any benefit with current medication management or usage. The specific request for the continued use of this agent at this chronic stage in the claimant's course of care would not be supported. The request for naproxen sodium tablet 550mg, 100 count, is not medically necessary or appropriate.