

<b>Case Number:</b>	CM14-0013979		
<b>Date Assigned:</b>	02/26/2014	<b>Date of Injury:</b>	02/06/2008
<b>Decision Date:</b>	06/27/2014	<b>UR Denial Date:</b>	01/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2014

### 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 Neurological 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 records presented for review indicate that this 42-year-old male was injured in February 2008. The mechanism of injury is not indicated. It is noted that the medication Protonix had been certified and multiple medications not certified. The currently listed diagnosis is a lumbar sprain/strain. The records reflect a recent exacerbation of the pain. Complaints reportedly occurred during exercise. Changes to the shoulder range of motion are reported. It is also noted there is a history of a lumbar and shoulder surgery. The December 2013 physical examination noted this 5'6", 230 pound individual to be normotensive. A slight decrease in lumbar spine range of motion is reported. Motor function is noted as 5/5. Muscle guarding in the lumbar spine is reported. A functional capacity evaluation was sought to establish a return to work. The follow-up assessment in January was essentially unchanged.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**FLEXERIL 7.5 MG #90, 1-2 TABLETS EVERY 4-6 HOURS AS NEEDED:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, MUSCLE RELAXANTS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 29 of 127.

**Decision rationale:** As outlined in the California Medical Treatment Utilization Schedule (CAMTUS) guidelines, muscle relaxants are limited to acute, temporary situations. The long term indefinite use is not supported. Furthermore, when noting the most recent progress of presented for review, it is clear this individual has reached maximum improvement and is ready to return to work. Therefore, there is insufficient data presented to support the indefinite, chronic use of such a medication. This is not supported clinically. The request is not medically necessary and appropriate.

**ANAPROX 550 MG #60, 1 TABLET ORALLY TWICE DAILY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-INFLAMMATORY DRUGS); NSAIDs, SPECIFIC DRUG LIST & ADVERSE EFF.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 30 of 127.

**Decision rationale:** When considering the date of injury, the injury sustained, the surgical interventions completed and the lack of objectification of a current inflammatory process, there is no clinical indication for this anti-inflammatory medication at this time. As outlined in the Chronic Pain Medical Treatment Guidelines, there are specific indicators for such medications and none are met. At most, over-the-counter analgesic preparation is all that would be necessary to address the current complaints. The request is not medically necessary and appropriate.

**NORCO 7.5/325 MG #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS, CRITERIA.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 77-80 of 127.

**Decision rationale:** This medication is a short acting opioid indicated for temporary relief of pain situation. According to Chronic Pain Medical Treatment Guidelines, the chronic use of such medications is indicated, if it demonstrates a certain efficacy. The progress note reflected over the last several months indicate the pain levels of 8/10 on the visual analog scale (VAS). As such, there is no noted efficacy. Given the risk factors with the use of opioid medications and the current clinical situation, there is no data presented to support this request. The request is not medically necessary and appropriate.

**REFILL TRAMCAP C + DIFLUR 120 G LOTION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESIC.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 56 of 127.

**Decision rationale:** The use of topical preparations is considered largely experimental. Furthermore, the medical records presented for review do not indicate any efficacy or utility with the utilization of such a topical compounded preparation. Lastly, as noted in the Chronic Pain Medical Treatment Guidelines, when one of the components of this topical preparation is not indicated, the entirety is not indicated. As demonstrated above, there is no indication for an anti-inflammatory component. As such, the entirety of this preparation is not clinically indicated. The request is not medically necessary and appropriate.

**PHYSICAL MEDICINE TREATMENT, 1-3 TIMES OVER A 2-WEEK PERIOD:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES; Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 98-99 of 127.

**Decision rationale:** When noting the date of injury, the treatment rendered, the amount of physical therapy as well as the transition to a home exercise protocol, there is no indication for formal physical therapy or physical medicine treatment at this time. This injured employee has transitioned to home exercise protocol and that is all that would be necessary. Furthermore, as outlined in the Chronic Pain Medical Treatment Guidelines, there is a limit to the amount of visits and that limit has long been exceeded. Therefore, based on the records presented for review, this request is not clinically indicated. The request is not medically necessary and appropriate.