

<b>Case Number:</b>	CM14-0016267		
<b>Date Assigned:</b>	04/11/2014	<b>Date of Injury:</b>	02/06/2011
<b>Decision Date:</b>	05/28/2014	<b>UR Denial Date:</b>	02/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Texas and Oklahoma. 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 33-year-old male who reported injury on 02/06/2011. The clinical documentation submitted for review failed to indicate the mechanism of injury. The injured worker's medication history included tramadol, omeprazole, cyclobenzaprine, and naproxen sodium as of 09/2013. The documentation of 12/17/2013 revealed the injured worker had symptomatology in the lumbar spine and feet that was essentially unchanged. The injured worker continued to have pain on the left side. The injured worker reported overall improvement in the symptomatology due to a right knee scope and debridement. The physical examination revealed the injured worker had pain with terminal motion of the lumbar spine, tenderness at the anterior joint line of the left knee, and pain with terminal flexion and crepitus. The diagnoses include status post right knee arthroscopy; status post left knee arthroscopic surgery with tear of medial meniscus, lumbar spine pain, plantar fasciitis, and psychiatric issues. The treatment plan included medication refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **PRESCRIPTION FOR CYCLOBENZAPRINE HYDROCHLORIDE TABLETS 7.5MG**

**#120:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines recommend muscle relaxants as a second-line option for the short-term treatment of acute low back pain, and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for 3 months. There was a lack of documentation of objective functional improvement. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for prescription for Cyclobenzaprine Hydrochloride tablets 7.5 mg #120 is not medically necessary.

**PRESCRIPTION FOR TRAMADOL HYDROCHLORIDE ER 150MG #90:** 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 Medications For Chronic Pain,Opioids Page(s): 60,78.

**Decision rationale:** California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for greater than 3 months. There was a lack of documentation of the above criteria. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for prescription for Tramadol HCl ER 150 mg #90 is not medically necessary.