

<b>Case Number:</b>	CM14-0111754		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	04/16/2012
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	06/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/17/2014

### 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, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 male, who reported an injury on 04/16/2012. The mechanism of injury was not submitted for clinical review. The diagnoses included recurrent right shoulder dislocation, herniated disc, musculoligamentous sprain of the thoracic spine, disc bulge, status post diagnostic arthroscopy, right biceps injury. The previous treatments included medication, physical therapy, and surgery. Within the clinical note dated 06/13/2014, it was reported the injured worker complained of pain. He rated his pain 8/10 to 9/10 in severity. The injured worker reported pain in the right shoulder with limited range of motion. He complained of mid and low back pain. He noted the pain radiated up and down his back. The injured worker complained of numbness to the right foot. Upon the physical examination, the provider noted the right shoulder abduction was 130 degrees. The provider requested Tramadol for pain, Midazolam/Melatonin, Methocarbamol, and Tramadol/Ondansetron. However, the Request for Authorization was not submitted for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol 50mg QTY: 100 with 3 refills: Upheld**

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

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

**Decision rationale:** The request for Tramadol 50mg QTY: 100 with 3 refills is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The provider failed to document an adequate and complete pain assessment within the physical examination. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. Additionally, the use of a urine drug screen was not submitted for clinical review. Therefore, the request is not medically necessary.

**Midazolam/Melatonin 10/3mg QTY: 30 capsule HS prn with 3 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Insomnia Treatments

**Decision rationale:** The request for Midazolam/Melatonin 10/3mg QTY: 30 capsule HS prn with 3 refills is not medically necessary. The California MTUS Guidelines note Midazolam is a benzodiazepine, which is not recommended for long term use due to long term efficacy being unproven and there is risk of dependence. The guidelines also recommend the limited use of Midazolam to 4 weeks. The injured worker has been utilizing the medication since at least 06/2014, which exceeds the guidelines' recommendation of short term use. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. Additionally, the Official Disability Guidelines note melatonin is used for the treatment of insomnia. There is lack of documentation indicating the injured worker is treated for insomnia. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. Therefore, the request is not medically necessary.

**Methocarbamol 750mg QTY: 90 1 capsule tid with 3 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63, 64.

**Decision rationale:** The request for Methocarbamol 750mg QTY: 90 1 capsule 3 times a day with 3 refills is not medically necessary. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. The guidelines do not recommend the

medication to be used for longer than 2 to 3 weeks. The injured worker has been utilizing the medication since at least 06/2014, which exceeds the guidelines' recommendation of short term use. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. Therefore, the request is not medically necessary.

**Tramadol/Ondansetron 100/250/2mg QTY: 90 1 capsule tid pm with 3 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://dailymed.nlm.nih.gov/dailymed/druginfo>

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Zofran

**Decision rationale:** The request for Tramadol/Ondansetron 100/250/2mg QTY: 90 1 capsule tid pm with 3 refills is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. In addition, the Official Disability Guidelines do not recommend the use of Ondansetron for nausea and vomiting secondary to chronic opioid use. The provider failed to document an adequate and complete pain assessment within the documentation. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. Additionally, the use of a urine drug screen was not submitted for clinical review. The clinical documentation submitted did not indicate the injured worker is treated for nausea and vomiting secondary to chronic opioid use. Therefore, the request is not medically necessary.