

<b>Case Number:</b>	CM14-0023513		
<b>Date Assigned:</b>	05/12/2014	<b>Date of Injury:</b>	08/31/2007
<b>Decision Date:</b>	07/18/2014	<b>UR Denial Date:</b>	02/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/24/2014

### 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 Minnesota. 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 58-year-old female who reported an injury on 08/31/2007 secondary to an unknown mechanism of injury. The injured worker was evaluated on 01/16/2014 for reports of low back, cervical, and knee pain. The exam notes indicated the low back pain had decreased to 4/10 after treatments with [REDACTED]. The exam noted mild dyesthesia to the posterior right forearm, positive cervical compression test, limited range of motion of the cervical spine, positive McMurray's sign to the right, and positive straight leg raise. The diagnoses included post-traumatic fibromyalgia syndrome, median neuropathy, ulnar neuropathy, radiculopathy, and radiculitis. The treatment plan included an EMG (electromyography) of the upper extremities, chiropractic treatments, exercise and stretching, and continued medication therapy. The Request for authorization and rationale for the request were not in the documentation provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**OXYCODONE 10MG:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

**Decision rationale:** The California MTUS Guidelines recommend the use of Opioids for the ongoing management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is evidence of an objective assessment of the injured worker's pain level, functional status, and evaluation of risk for aberrant drug use behavior and side effects; however, the request does not indicate the total number of tablets requested. Therefore, based on the documentation provided, the request for Oxycodone is not medically necessary.

**CYCLOBENZAPRINE 10MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) and NSAIDs Page(s): 78, 82, 86, and 89.

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

**Decision rationale:** The California MTUS Guidelines recommend the use of muscle relaxants with caution as a second line option for short term treatment of acute exacerbations in injured workers with chronic low back pain. The documentation provided indicates that the injured worker has been prescribed muscle relaxants since at least 08/01/2013. This time frame exceeds the time frame to be considered short term. Furthermore, the request does not indicate the total number of tablets requested. Therefore, the request for Cyclobenzaprine is not medically necessary.

**IBUPROFEN 800MG:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

**Decision rationale:** The California MTUS Guidelines state the use of non-steroidal anti-inflammatory drugs (NSAIDs) is recommended as an option for short term symptomatic relief of pain. However, there is no significant clinical evidence in the documentation provided of the efficacy of the prescribed medication. Furthermore, the request does not indicate the total number of tablets requested. Therefore, based on the documentation provided, the request for Ibuprofen is not medically necessary.