

<b>Case Number:</b>	CM14-0023770		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	06/28/2005
<b>Decision Date:</b>	08/11/2014	<b>UR Denial Date:</b>	02/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/25/2014

### 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 & Rehabilitation 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 injured worker is a 53-year-old male who reported an injury on 06/28/2005. The mechanism of injury was not provided for clinical review. The diagnosis included lumbar spine spondylosis. Treatments include medication. Within the clinical note dated 02/03/2014 it was reported the injured worker complained of lumbar spine pain. The injured worker complained of pain with bending, lifting, and stooping, prolonged sitting. He complained of numbness and tingling in the left lower extremity. The injured worker complained of radiating pain extending to the left lower extremity. Upon physical examination of the lumbar spine, the provider noted range of motion with extension at 20 degrees. The provider indicated the injured worker had tenderness to palpation over the paravertebral musculature. The provider indicated spasms were present. The injured worker had decreased sensation over the left lower extremity. The injured worker had a positive straight leg raise. The provider requested for prescription for cyclobenzaprine/tramadol, flurbiprofen, and hydrocodone. However, a rationale was not provided for clinical review. The request for authorization was not provided for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION FOR CYCLO/TRAMA 10/10%, 30 GM.:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

**Decision rationale:** The injured worker complained of pain in the lumbar spine with bending, lifting, stooping, and prolonged sitting. He complained of numbness and tingling in the left lower extremity. He complained of radiating pain extending from the left lower extremity. The California MTUS Guidelines note topical NSAIDs are recommended for osteoarthritis, tendinitis, and in particular, that of the knee and/or other joints that are amenable. Topical NSAIDs are recommended for short-term use for 4 to 12 weeks. There is little evidence to utilize topical NSAIDs for the treatment of osteoarthritis of the spine, hip, or shoulder. Cyclobenzaprine is recommended for a short course of therapy. The guidelines note cyclobenzaprine is a muscle relaxant. Tramadol is a centrally-acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. The guidelines note there is no evidence for use of any other muscle relaxant as a topical product. There is a lack of documentation indicating the injured worker is treated for or diagnosed with osteoarthritis or tendinitis. The injured worker has been utilizing the medication since at least 10/2013 which exceeds the guideline's recommendation of short-term use of 4 to 12 weeks. There is lack of documentation indicating efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the retrospective request for 1 prescription for cyclo/trama 10/10%, 30 GM (DOS: 11/13/13) is not medically necessary and appropriate.

**RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION FOR FLURBIPROFEN 25%, 30 GM.: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

**Decision rationale:** The injured worker complained of pain in the lumbar spine with bending, lifting, stooping, and prolonged sitting. He complained of numbness and tingling in the left lower extremity. He complained of radiating pain extending from the left lower extremity. The California MTUS Guidelines note topical NSAIDs are recommended for the use of osteoarthritis and tendinitis, in particular, that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short-term use of 4 to 12 weeks. There is little evidence to utilize topical NSAIDs for the treatment of osteoarthritis in the spine, hip, or shoulder. Flurbiprofen is indicated for osteoarthritis in mild to moderate pain. The injured worker has been utilizing the medication for an extended period of time since at least 10/2013 which exceeds the guideline's recommendation of short-term use for 4 to 12 weeks. The request submitted failed to provide the frequency of the medication. In addition, there is lack of documentation indicating the efficacy of the medication is evidenced by significant functional improvement. Therefore, the retrospective request for 1 prescription for flurbiprofen 25%, 30 GM (DOS: 11/13/13) is not medically necessary and appropriate.

**RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION FOR HYDROCODONE/ APAP 10/325 MG., # 180: Upheld**

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

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

**Decision rationale:** The retrospective request for 1 prescription of hydrocodone/APAP 10/325 mg #180 is non-certified. The injured worker complained of pain in the lumbar spine with bending, lifting, stooping, and prolonged sitting. He complained of numbness and tingling in the left lower extremity. He complained of radiating pain extending from the left lower extremity. 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 urine drug screen for inpatient treatment of issues of abuse, addiction, and poor pain control. The provider did not document adequate and complete pain assessment within the documentation. There is lack of documentation indicating the medication had been providing objective functional improvement and improvement. The request submitted failed to provide the frequency of the medication. The injured worker has been utilizing the medication since at least 10/2013. Additionally, the use of a urine drug screen was not provided for clinical review. Therefore, the retrospective request for 1 prescription for hydrocodone/APAP 10/325 MG #180 (DOS: 11/13/13) is not medically necessary and appropriate.

**RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION FOR HYDROCODONE? APAP 7.5/325, #60: Upheld**

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

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

**Decision rationale:** The injured worker complained of pain in the lumbar spine with bending, lifting, stooping, and prolonged sitting. He complained of numbness and tingling in the left lower extremity. He complained of radiating pain extending from the left lower extremity. 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 urine drug screen for inpatient treatment of issues of abuse, addiction, and poor pain control. The provider did not document adequate and complete pain assessment within the documentation. There is lack of documentation indicating the medication had been providing objective functional improvement and improvement. The request submitted failed to provide the frequency of the medication. The injured worker has been utilizing the medication since at least 10/2013. Additionally, the use of a urine drug screen was not provided for clinical review. Therefore, the retrospective request for 1 prescription for hydrocodone/APAP 7.5/325 #60 (DOS: 11/13/13) is not medically necessary and appropriate.

