

<b>Case Number:</b>	CM14-0031566		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	09/22/2009
<b>Decision Date:</b>	07/21/2014	<b>UR Denial Date:</b>	02/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2014

### 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 Occupational 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 47 year old male who sustained an injury on 09/22/09 while lifting buckets of wet plaster. The injured worker felt a pop in the lower left back with associated burning symptoms. The injured worker has been treated previously with epidural steroid injections in 2012. The injured worker did have a transforaminal lumbar interbody fusion completed on 10/25/12. Following surgery, the injured worker continued to report severe low back pain with the inability to sit or stand for long periods of time due to symptoms. Prior medications included ketoprofen and gabapentin; however, the injured worker did have side effects with these medications. The injured worker did attend physical therapy in 2013. Electrodiagnostic studies from July of 2013 did note evidence of a mild to moderate left S1 radiculopathy. The injured worker was reported to have cramping and side effects with the use of Tramadol and Vicodin. Urine toxicology testing from 12/24/13 was noted to be positive for the use of Tramadol. The injured worker was being followed by [REDACTED] for pain management. The clinical report on 01/29/14 noted that the injured worker continued to have complaints of low back pain more severe in the upper and lower lumbar regions. The injured worker also described severe pain radiating to the lower extremities. Physical examination noted no motor weakness in the lower extremities. There was decreased sensation in a bilateral L5 distribution. The injured worker was recommended to be seen by an acupuncturist. There were also recommendations for facet and hardware blocks. There was a recommendation for a functional capacity evaluation. Prescription medications included tramadol, Flexeril, and Prilosec. The injured worker did have a functional capacity evaluation completed on 02/21/14 which found the injured worker did have continued functional impairments that prevented him from performing in his normal industry. Follow up on 03/12/14 noted the injured worker continued to have tenderness and significant guarding in the lumbar region with limited range of

motion. No swelling or muscular spasms were identified. Straight leg raise was reported as positive to the left. Decreased sensation was also noted in a left L5 and S1 distribution. The injured worker did describe worsening with any activities. Medications at this evaluation did include tramadol for pain. The requested functional capacity evaluation, Flexeril 10mg, Prilosec, and tramadol 50mg, quantity 30 were all denied by utilization review on 02/24/14.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Functional Capacity Evaluation QTY: 1.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 15.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty, Functional capacity evaluation.

**Decision rationale:** In regards to the request for a functional capacity evaluation, this was completed on 02/21/14 per the clinical records. In review of the records there was no clear discussion regarding the need for a functional capacity evaluation for the injured worker. There was no indication that the injured worker had been considered to be at or near MMI. There were no ongoing issues returning a return to work or a question regarding the injured worker's work restrictions. Given the lack of any clear clinical indication for the use of a functional capacity evaluation as outlined by guidelines, this reviewer would not have recommended this request as medically necessary.

#### **Flexeril 10 mg, QTY: 1.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-67.

**Decision rationale:** In regards to the use of Flexeril 10mg, this medication is not medically necessary based on the clinical documentatin provdied for review and current evidence based guideline recommendations. The chronic use of muscle relaxers is not recommended by current evidence based guidelines. At most, muscle relaxers are recommended for short term use only. The efficacy of chronic muscle relaxer use is not established in the clinical literature. There is no indication from the clinical reports that there had been any recent exacerbation of chronic pain or any evidence of a recent acute injury. Furthermore, the request is non-specific in regards to frequency, duration, or quantity. Therefore, this reviewer would not have recommended ongoing use of this medication.

#### **Prilosec, QTY: 1.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & Cardiovascular Risk.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, proton pump inhibitors.

**Decision rationale:** In regards to the use of Prilosec, this medication is not medically necessary based on the clinical documentatin provided for review and current evidence based guideline recommendations. The clinical records provided for review did not discuss any side effects from oral medication usage including gastritis or acid reflux. There was no other documentation provided to support a diagnosis of gastroesophageal reflux disease. Furthermore, the request is non-specific in regards to dose, duration, frequency, or quantity. Given the lack of any clinical indication for the use of a proton pump inhibitor this reviewer would not have recommended this request as medically necessary.