

<b>Case Number:</b>	CM14-0033579		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	12/13/2011
<b>Decision Date:</b>	09/08/2014	<b>UR Denial Date:</b>	02/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/17/2014

### 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 Oklahoma and 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 61-year-old female who reported an injury on 12/13/2011 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to her neck, with radiating pain into the bilateral upper extremities, and low back, with radiating pain into the bilateral lower extremities. The Qualified Medical Evaluation dated 01/22/2014 was submitted for review. It reported that the injured worker was evaluated on 06/25/2012 and reported pain levels from a 3/10 to 4/10 at the jaw, neck pain at a 3/10 to 8/10 and considered improved and low back pain rated at a 4/10 to 8/10 and considered improved. It was noted that the injured worker was able to perform most of her usual work; however, functional Activities of Daily Living exacerbated the injured worker's pain. There was no documentation of an appointment from 08/08/2012 within the submitted designated doctor's report. It was noted that the injured worker was evaluated on 10/10/2012 and that the injured worker reported excruciating pain; however, she had refused epidural steroid injections. It was noted that the injured worker had 8/10 pain and had treated with medications to include Anaprox, Zanaflex, and Prilosec as well as Tramadol and topical analgesics. There was no documentation of an appointment from 01/22/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Naproxen Sodium 550mg Tab #60 (Retro DOS 06/25/12, 08/08/12, 10/10/12, 01/22/13 ):**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Page(s): 60.

**Decision rationale:** The requested Naproxen Sodium 550 mg tablets #60 retrospective from dates of service of 06/25/2012, 08/08/2012, 10/10/2012 and 01/22/2013 is not medically necessary or appropriate. The clinical documentation submitted for review did provide a Designated Doctor Evaluation and assessment of the clinical notes from the requested dates of service. However, the actual documentation from the requested dates of service was not provided. Within the Designated Doctor Evaluation, there was no documentation of increased functional benefit or pain relief resulting from medication usage. The California Medical Treatment Utilization Schedule recommends that ongoing use of medications in the management of chronic pain be supported by documented functional benefit and evidence of pain relief. As there was no documentation to indicate pain relief or functional benefit resulting from medication usage from the actual requested dates of service, the appropriateness of the request cannot be determined. As such, the requested Naproxen Sodium 550 mg tablets #60 retrospective dates of service of 06/25/2012, 08/08/2012, 10/10/2012 and 01/22/2013 is not medically necessary or appropriate.

**Tizanidine Hcl 4mg Tab X60, (Retro DOS 04/02/12, 06/25/12, 08/08/12, 10/10/12, 01/22/13 ):**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Page(s): 60.

**Decision rationale:** The requested Tizanidine Hydrochloride 4 mg tablets #60 retrospective from dates of service of 04/02/2012, 06/25/2012, 08/08/2012, 10/10/2012 and 01/22/2013 is not medically necessary or appropriate. The clinical documentation submitted for review did provide a Designated Doctor Evaluation and assessment of the clinical notes from the requested dates of service. However, the actual documentation from the requested dates of service was not provided. Within the Designated Doctor Evaluation, there was no documentation of increased functional benefit or pain relief resulting from medication usage. The California Medical Treatment Utilization Schedule recommends that ongoing use of medications in the management of chronic pain be supported by documented functional benefit and evidence of pain relief. As there was no documentation to indicate pain relief or functional benefit resulting from medication usage from the actual requested dates of service, the appropriateness of the request cannot be determined. As such, the requested tizanidine hydrochloride 4 mg tablets #60 retrospective dates of service of 04/02/2012, 06/25/2012, 08/08/2012, 10/10/2012 and 01/22/2013 is not medically necessary or appropriate.

**Omeprazole DR 20mg #60 (Retro DOS, 06/25/12, 08/08/12, 10/10/12, 01/22/13 ): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Page(s): 60.

**Decision rationale:** The requested Omeprazole DR 20 mg tablets #60 retrospective from dates of service of 06/25/2012, 08/08/2012, 10/10/2012 and 01/22/2013 is not medically necessary or appropriate. The clinical documentation submitted for review did provide a Designated Doctor Evaluation and assessment of the clinical notes from the requested dates of service. However, the actual documentation from the requested dates of service was not provided. Within the Designated Doctor Evaluation, there was no documentation of increased functional benefit or pain relief resulting from medication usage. The California Medical Treatment Utilization Schedule recommends that ongoing use of medications in the management of chronic pain be supported by documented functional benefit and evidence of pain relief. As there was no documentation to indicate pain relief or functional benefit resulting from medication usage from the actual requested dates of service, the appropriateness of the request cannot be determined. As such, the requested Omeprazole DR 20 mg tablets #60 retrospective dates of service of 06/25/2012, 08/08/2012, 10/10/2012 and 01/22/2013 is not medically necessary or appropriate.

**Keto/Lido/Carb 20-5-5% Cream #150 (Retro DOS 04/02/12, 06/25/12, 08/08/12, 10/10/12, 01/22/13 ): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Page(s): 60.

**Decision rationale:** The requested keto/lido/carb 20%/5%/5% cream #150 retrospective from dates of service of 04/02/2012, 06/25/2012, 08/08/2012, 10/10/2012 and 01/22/2013 is not medically necessary or appropriate. The clinical documentation submitted for review did provide a Designated Doctor Evaluation and assessment of the clinical notes from the requested dates of service. However, the actual documentation from the requested dates of service was not provided. Within the Designated Doctor Evaluation, there was no documentation of increased functional benefit or pain relief resulting from medication usage. The California Medical Treatment Utilization Schedule recommends that ongoing use of medications in the management of chronic pain be supported by documented functional benefit and evidence of pain relief. As there was no documentation to indicate pain relief or functional benefit resulting from medication usage from the actual requested dates of service, the appropriateness of the request cannot be determined. As such, the requested keto/lido/carb 20%/5%/5% cream #150 retrospective dates of service of 04/02/2012, 06/25/2012, 08/08/2012, 10/10/2012 and 01/22/2013 is not medically necessary or appropriate.

**Cyclo-Gaba 10% 10% Gel #150 (DOS 04/02/12, 06/25/12, 08/08/12, 10/10/12, 01/22/13):**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Medications for Chronic Pain Page(s): 60.

**Decision rationale:** The requested cyclo/gaba 10%/10% gel #150 retrospective from dates of service of 04/02/2012, 06/25/2012, 08/08/2012, 10/10/2012 and 01/22/2013 is not medically necessary or appropriate. The clinical documentation submitted for review did provide a Designated Doctor Evaluation and assessment of the clinical notes from the requested dates of service. However, the actual documentation from the requested dates of service was not provided. Within the Designated Doctor Evaluation, there was no documentation of increased functional benefit or pain relief resulting from medication usage. The California Medical Treatment Utilization Schedule recommends that ongoing use of medications in the management of chronic pain be supported by documented functional benefit and evidence of pain relief. As there was no documentation to indicate pain relief or functional benefit resulting from medication usage from the actual requested dates of service, the appropriateness of the request cannot be determined. As such, the requested cyclo/gaba 10%/10% gel #150 retrospective dates of service of 04/02/2012, 06/25/2012, 08/08/2012, 10/10/2012 and 01/22/2013 is not medically necessary or appropriate.

**Tramadol 20% Cream #150 (Retro DOS 04/02/12, 06/25/12, 08/08/12, 10/10/12, 01/22/13):**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Medication for Chronic Pain Page(s): 60.

**Decision rationale:** The requested Tramadol 20% Cream #150 retrospective from dates of service of 04/02/2012, 06/25/2012, 08/08/2012, 10/10/2012 and 01/22/2013 is not medically necessary or appropriate. The clinical documentation submitted for review did provide a Designated Doctor Evaluation and assessment of the clinical notes from the requested dates of service. However, the actual documentation from the requested dates of service was not provided. Within the Designated Doctor Evaluation, there was no documentation of increased functional benefit or pain relief resulting from medication usage. The California Medical Treatment Utilization Schedule recommends that ongoing use of medications in the management of chronic pain be supported by documented functional benefit and evidence of pain relief. As there was no documentation to indicate pain relief or functional benefit resulting from medication usage from the actual requested dates of service, the appropriateness of the request cannot be determined. As such, the requested Tramadol 20% Cream #150 retrospective dates of

service of 04/02/2012, 06/25/2012, 08/08/2012, 10/10/2012 and 01/22/2013 is not medically necessary or appropriate.

**Alprazolam 0.25mg #30 (Retro DOS 06/25/12, 08/08/12, 10/10/12, 01/22/13 ):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Page(s): 60.

**Decision rationale:** The requested Alprazolam 0.25 mg #30 retrospective from dates of service of 06/25/2012, 08/08/2012, 10/10/2012 and 01/22/2013 is not medically necessary or appropriate. The clinical documentation submitted for review did provide a Designated Doctor Evaluation and assessment of the clinical notes from the requested dates of service. However, the actual documentation from the requested dates of service was not provided. Within the Designated Doctor Evaluation, there was no documentation of increased functional benefit or pain relief resulting from medication usage. The California Medical Treatment Utilization Schedule recommends that ongoing use of medications in the management of chronic pain be supported by documented functional benefit and evidence of pain relief. As there was no documentation to indicate pain relief or functional benefit resulting from medication usage from the actual requested dates of service, the appropriateness of the request cannot be determined. As such, the requested Alprazolam 0.25 mg #30 retrospective dates of service of 06/25/2012, 08/08/2012, 10/10/2012 and 01/22/2013 is not medically necessary or appropriate.