

<b>Case Number:</b>	CM14-0042701		
<b>Date Assigned:</b>	06/30/2014	<b>Date of Injury:</b>	01/06/2012
<b>Decision Date:</b>	08/19/2014	<b>UR Denial Date:</b>	03/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/09/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine 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 57 year old female who had a work-related injury on 01/06/12. She was working as a certified nursing assistant for home care assistance. She was performing her usual job duties which require her to transfer a client to the restroom and from chairs to bed; she developed progressive pain in her lower back, right arm, neck and leg. She began treatment with a chiropractor, approximately a year and nine months later. She was receiving chiropractic care and acupuncture. She was provided with medication and back support on 02/03/14. She was seen for ongoing mid and low back pain and intermittent right-sided neck pain. She also has pain and numbness in the arm. She had complaints in her right knee as well. Physical examination showed normal power, reflexes, and sensations in the upper extremities. There was normal power, reflexes and sensation in the lower extremities. Spurling's test was negative. She had equivocal impingement and mild tenderness in the right shoulder. She had tenderness in the lumbar spine with approximately 20% loss of range of motion. There is no documentation of any muscle spasm. Prior utilization review completed on 02/03/14 was non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective request (DOS: 2/3/14) for Fexmid/Cyclobenzaprine 7.5MG #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Flexeril Page(s): 41. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, muscle relaxants for pain.

**Decision rationale:** The request for retrospective request (Date Of Service: 02/03/14) for Fexmid/Cyclobenzaprine 7.5 mg, #60 is not medically necessary. The clinical documentation submitted for review as well as current guidelines do not support the request. Recommend non-sedating muscle relaxants with caution as a second-line option for short-term (less than two weeks) treatment of acute low blood pressure (LBP) and for short-term treatment of acute exacerbations in patients with chronic LBP. Therefore medical necessity has not been established.

**Retrospective request (DOS: 2/3/14) for Ultram/Tramadol HCL ER 150MGS #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93-94.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Page(s): 74-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, opioid's.

**Decision rationale:** The request for retrospective request (Date Of Service: 02/03/14) for Ultram/tramadol HCL ER 150 mg, #60 is not medically necessary. The clinical documentation submitted for review does not support the request. There is no documentation of functional improvement or decrease in pain while on the medication. Therefore medical necessity has not been established.

**Retrospective request (DOS: 2/3/14) for Methoderm Ointment 120ML x 1:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, topical analgesics.

**Decision rationale:** The request for retrospective request (Date Of Service: 02/03/14) for Methoderm Ointment 120ml times 1 is not medically necessary. Current guidelines do not support the request. Methoderm Ointment is largely experimental in use with few randomized controlled trials to determine efficacy or safety, primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Therefore medical necessity has not been established.