

<b>Case Number:</b>	CM14-0055441		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	05/02/2012
<b>Decision Date:</b>	09/08/2014	<b>UR Denial Date:</b>	04/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/24/2014

### 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 and is licensed to practice in Nevada. 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 59-year-old male who was reportedly injured on May 2, 2012. The mechanism of injury was not listed in these records reviewed. The most recent progress note dated April 2, 2014, indicated that there were ongoing complaints of neck pain, low back pain, shoulder pain and right knee pain. The physical examination demonstrated tenderness to palpation and a reduced range of motion in the above regions. Diagnostic imaging studies were not reviewed. Previous treatment included multiple medications. A request was made for multiple medications and was not certified in the pre-authorization process on April 15, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Naproxen Sodium 550mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 66, 73.

**Decision rationale:** The only progress notes presented for review list no noted efficacy, utility, functional improvement or relief of symptomatology associated with this medication. As such,

while noting that the California Medical Treatment Utilization Schedule does recommend this medication in objectification of some clinical improvement, the medical necessity has not been established.

**Cyclobenzaprine HCL 7.5 mg #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009): Muscle relaxants Page(s): 41, 64.

**Decision rationale:** As noted in the California Medical Treatment Utilization Schedule, there is support for skeletal muscle relaxant type medications; however, this is limited for short-term use to address occasional flare-ups of symptomatology. There is no clinical indication or recommendation for chronic, long-term or indefinite use. As such, based on the clinical records presented for review, there is insufficient data presented to establish the medical necessity.

**Ondansetron ODT tablets 8mg #60: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**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, updated July 2014.

**Decision rationale:** This medication is not addressed in the California Medical Treatment Utilization Schedule guidelines. The parameters noted in the Official Disability Guidelines are noted. This has been approved for nausea and vomiting secondary to chemotherapy, radiation therapy or postoperatively. None of these indications for use are noted to exist. Furthermore, the progress notes presented did not indicate there were any complaints relative to nausea and/or vomiting. As such, the medical necessity has not been established.

**Omeprazole delayed release capsules 20mg #120: 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 (Effective July 18, 2009) Page(s): 68.

**Decision rationale:** This medication is a proton pump inhibitor useful for the treatment of gastroesophageal reflux disease (GERD) and is considered a gastric protectant for individuals utilizing non-steroidal anti-inflammatory medications. There is no indication in the record provided of a gastrointestinal disorder. Additionally, the claimant does not have a significant

risk factor for potential gastrointestinal complications as outlined by the California Medical Treatment Utilization Schedule. Therefore, the use of this medication is not clinically indicated and is not medically necessary.

**Tramadol HCL ER 150 mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 82, 113.

**Decision rationale:** This medication is a centrally acting synthetic opioid analgesic. This is not recommended as a first-line oral analgesic. There are no progress notes presented for review demonstrating the efficacy or utility of this medication. There is no notation of any improved functionality, decrease in pain complaints or the other parameters by which this should be continued. As such, this is not medically necessary.