

<b>Case Number:</b>	CM14-0056976		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	05/16/2011
<b>Decision Date:</b>	10/23/2014	<b>UR Denial Date:</b>	03/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/28/2014

### 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 Texas and Ohio. 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 50-year-old female who reported an injury on 05/15/2011. The mechanism of injury was not submitted for clinical review. The diagnoses included joint inflammation, coccydynia, and element of weight gain, depression, and insomnia. The previous treatments included medication and a TENS unit. The diagnostic testing included an MRI. Within the clinical note dated 03/07/2014 it was reported the injured worker complained of left hip and coccygeal pain. Upon physical examination, the provider noted the injured worker had tenderness along the hip noted, as well as the coccyx area. Motion of the hip was limited. The provider requested Flexeril, naproxen, tramadol, and Protonix, trazodone, Lidopro cream, and Terocin patches. However, a rationale was not submitted for clinical review. The Request for Authorization was not submitted for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flexeril 7.6 mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41,64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

**Decision rationale:** The request for Flexeril 7.6 mg #60 is not medically necessary. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. The guidelines do not recommend the use of the medication for longer than 2 to 3 weeks. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the injured worker has been utilizing the medication since at least 03/2014, which exceeds the guidelines' recommendation of short term use. Therefore, the request is not medically necessary.

**Naproxen 550mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen Page(s): 66-67.

**Decision rationale:** The request for Naproxen 550mg #60 is not medically necessary. The California MTUS Guidelines note naproxen is a nonsteroidal anti-inflammatory drug for the relief of the signs and symptoms of osteoarthritis. The guidelines recommend naproxen at the lowest dose for the shortest period of time in patients with moderate to severe pain. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the injured worker has been utilizing the medication for an extended period of time, since at least 03/2014. Therefore, the request is not medically necessary.

**Tramadol ER 150mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 91.

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

**Decision rationale:** The request for Tramadol ER 150mg #30 is not medically necessary. 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 a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The provider did not document an adequate and complete pain assessment within the documentation. There is a lack of documentation indicating the medication had been providing objective functional benefit and improvement. Additionally, the use of a urine drug screen was not submitted for clinical review. Therefore, the request is not medically necessary.

**Protonix 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines GI symptoms & cardiovascular risk Page(s): 68-69.

**Decision rationale:** The request for Protonix 20mg #60 is not medically necessary. The California MTUS Guidelines note proton pump inhibitors such as Protonix are recommended for injured workers at risk for gastrointestinal events and/or cardiovascular disease. The risk factors for gastrointestinal events include over the age of 65, history of peptic ulcer, gastrointestinal bleeding or perforation, use of corticosteroids and/or anticoagulants. In the absence of risk factors for gastrointestinal events, proton pump inhibitors are not indicated when taking NSAIDs. The treatment of dyspepsia from NSAID usage includes stopping the NSAID, switching to a different NSAID, adding an H2 receptor antagonist or proton pump inhibitor. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, there is a lack of clinical documentation indicating the injured worker had a diagnosis of dyspepsia secondary to NSAID therapy. Therefore, the request is not medically necessary.

**Trazodone 50mg #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), Pain Chapter, Insomnia Treatment

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

**Decision rationale:** The request for Trazodone 50mg #60 is not medically necessary. 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 a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is a lack of documentation indicating the medication had been providing objective functional benefit and improvement. The provider did not document an adequate and complete pain assessment within the documentation. Additionally, the use of a urine drug screen was not submitted for clinical review. Therefore, the request is not medically necessary.

**Lidopro Cream 4-Ounces:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

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

**Decision rationale:** The request for LidoPro Cream 4-Ounces is not medically necessary. The California MTUS Guidelines note topical NSAIDs are recommended for 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 was a lack of documentation indicating the medication had been providing objective functional improvement and benefits. The request submitted failed to provide the frequency of the medication. The request submitted failed to provide the treatment site. Additionally, the injured worker has been utilizing the medication for an extended period of time, since at least 03/2014, which exceeds the guidelines recommendation of short term use. Therefore, the request is not medically necessary.

**Terocin Patches #20:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

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

**Decision rationale:** The request for Terocin Patches #20 is not medically necessary. The California MTUS Guidelines note topical NSAIDs are recommended for 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 a lack of documentation indicating the medication had been providing objective functional improvement and benefits. The request submitted failed to provide the frequency of the medication. The request submitted failed to provide the treatment site. Additionally, the injured worker has been utilizing the medication for an extended period of time, since at least 03/2014, which exceeds the guidelines recommendation of short term use. Therefore, the request is not medically necessary.