

<b>Case Number:</b>	CM14-0060858		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	10/15/2012
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	04/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/01/2014

### 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 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:

Patient is a 40-year-old male who has submitted a claim for iliolumbar strain, lumbosacral radiculopathy, lumbar degenerative disc disease, and spondylosis associated with an industrial injury date of 10/15/2012. Medical records from 2014 were reviewed. Patient complained of low back pain associated with numbness and tingling sensation at the posterior gluteal, thigh, and calf bilaterally. Pain was associated with muscle spasm and weakness. Aggravating factors included coughing, bending forward, lifting, pushing, pulling, prolonged sitting, and standing. Range of motion of the lumbar spine was mildly restricted. Straight leg raise test was negative. There were no trigger points noted. Muscle tone was normal. Motor strength and sensation were intact. Reflexes were symmetric graded 1+. Treatment to date has included physical therapy, chiropractic care, heat therapy, activity modification, use of a TENS unit, trigger point injections, lumbar epidural steroid injection, home exercise program, and medications such as Flexeril, Norco, and Ibuprofen. Utilization review from 04/24/2014 denied the request for Flexeril 10 mg because there was no description of an acute exacerbation of muscle spasm; denied Percocet 10/325 mg because there was no documentation concerning analgesia or functional benefit; certified Gabapentin 300 mg because patient presented with chronic neuropathic pain; denied Trazadone 100 mg because there was no description of insomnia in this patient; and denied Physical Therapy (PT) x 6 because there was no further documentation to substantiate the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flexeril 10 mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

**Decision rationale:** According to pages 41-42 of the CA MTUS Chronic Pain Medical Treatment Guidelines, sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In this case, the patient has been on Flexeril since 2012. However, long-term use is not recommended. Moreover, the most recent physical examination failed to provide evidence of muscle spasm. Therefore, the request for Flexeril 10 mg is not medically necessary.

**Percocet 10/325 mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81. Decision based on Non-MTUS Citation American Pain Society and the American Academy of Pain Medicine, Opioid Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**Decision rationale:** As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on opioids since 2012. However, the medical records did not clearly reflect continued analgesia, continued functional benefit, or a lack of adverse side effects. MTUS Guidelines require clear and concise documentation for ongoing management. The request likewise failed to specify quantity to be dispensed. Therefore, the request for Percocet 10/325 mg is not medically necessary.

**Trazadone 100 mg:** 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:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13-14.

**Decision rationale:** As stated on page 14 of CA MTUS Chronic Pain Medical Treatment Guidelines, tricyclic antidepressants, such as amitriptyline and nortriptyline, are recommended as a first-line option for neuropathic pain, especially if pain is accompanied by insomnia, anxiety,

or depression. In this case, there was no documented indication for Trazodone. A discussion concerning sleep hygiene or emotional complaint was not evident in the records submitted. The medical necessity cannot be established due to insufficient information. Therefore, the request for Trazodone 100 mg is not medically necessary.

**Physical Therapy (PT) x 6: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Pain, Suffering, and the restoration of Function Chapter Official Disability Guidelines (ODG): Lumbar sprains and strains.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** As stated on pages 98-99 of the California MTUS Chronic Pain Medical Treatment Guidelines, physical medicine is recommended and that given frequency should be tapered and transition into a self-directed home program. In this case, patient previously underwent physical therapy. A report from 4/4/13 cited that physical therapy was not beneficial. There was no clear indication presented to support the request for additional therapy sessions. Moreover, the request failed to specify body part to be treated. Therefore, the request for physical therapy x 6 is not medically necessary.