

<b>Case Number:</b>	CM14-0079483		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	10/25/1999
<b>Decision Date:</b>	09/23/2014	<b>UR Denial Date:</b>	05/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/30/2014

### 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 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 48-year-old male who reported an injury on 10/25/1999 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to his low back. The injured worker's treatment history included acupuncture, physical therapy, medications, and surgical intervention. The injured worker was evaluated on 04/16/2014. It was documented that the injured worker had constant low back pain with radiculopathy. Physical findings included restricted range of motion of the lumbar spine with tenderness to palpation and spasming and a positive straight leg raising test. The injured worker's treatment plan included physical therapy, acupuncture, and medication refill. The actual medications being requested were not provided in the most recent documentation. Additionally, a Request for Authorization form to support the request was also not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol ER 150 MG # 90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ultram (tramadol).

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

**Decision rationale:** The request Tramadol ER 150 MG # 90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management chronic pain be supported by documented functional benefit, quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the injured worker is monitored for aberrant behavior. Additionally, there is no documentation of a quantitative assessment of pain relief or functional benefit. The clinical documentation indicates that the injured worker has been using this medication since 04/2013. An established history of pain relief and functional benefit as not provided as a result of this medication. Therefore, ongoing use would not be indicated in this clinical situation. Additionally, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Tramadol ER 150 MG # 90 is not medically necessary or appropriate.

**Cyclobenzaprine 7.5MG # 120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril).

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

**Decision rationale:** The requested Cyclobenzaprine 7.5MG # 120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not support the long term use of muscle relaxants in the management of chronic pain. California Medical Treatment Utilization Schedule recommends short durations of treatment not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 03/2012. This exceeds guideline recommendations. Therefore, ongoing use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Cyclobenzaprine 7.5MG # 120 is not medically necessary or appropriate.

**Omeprazole 20 MG # 120:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment for Workers Compensation, Proton Pump Inhibitors (PPI's).

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

**Decision rationale:** The requested Omeprazole 20 MG # 120 is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has been taking this medication since at least 03/2012. California Medical Treatment Utilization Schedule recommends the ongoing use of gastrointestinal protectants be supported by

documented risk factors of gastrointestinal disturbances related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's gastrointestinal system to support ongoing risk factors that require medication intervention. Additionally, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Omeprazole 20 MG # 120 is not medically necessary or appropriate.

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

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain and NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67.

**Decision rationale:** The requested Naproxen Sodium 550 MG #120 is not medically necessary or appropriate. The clinical documentation submitted for review indicates that the injured worker has been on this medication since at least 03/2012. California Medical Treatment Utilization Schedule does recommend nonsteroidal anti-inflammatory drugs as first line treatments in the management of chronic pain. California Medical Treatment Utilization Schedule also recommends that medications used for chronic pain be supported by documented functional benefit and evidence of pain relief. The clinical documentation submitted for review did not provide any evidence of significant pain relief or increased functionality related to medication usage. Therefore, ongoing use would not be supported in this clinical situation. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Naproxen Sodium 550 MG #120 is not medically necessary or appropriate.