

<b>Case Number:</b>	CM14-0082365		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	01/31/2006
<b>Decision Date:</b>	10/10/2014	<b>UR Denial Date:</b>	05/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2014

### 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 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 68 year-old male who was reportedly injured on 1/31/2006. The mechanism of injury is noted as a fall due to a syncopal episode. The most recent progress note dated 4/21/2014. Indicates that there are ongoing complaints of low back and right knee pain. The physical examination demonstrated lumbar spine: decreased range of motion. Positive tenderness to palpation paraspinal muscles left greater than right. Positive Kemps sign, positive straight leg raise on the left at 70 to posterior thigh. Motor and sensory exam within normal limits. Deep tendon reflexes 2+ bilaterally. Bilateral knees: decreased range of motion on the right 90-0. Left 5-100. Positive tenderness to palpation medial/lateral joint line as well as decreased strength 4/5 at the quadriceps bilaterally. No reason diagnostic studies are available for review. Previous treatment includes total knee arthroplasty, physical therapy, medications and conservative treatment. A request was made for Ultram 50mg #60, Flexeril 10mg #60, and was not certified in the pre-authorization process on 5/19/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultram (Tramadol 50mg) #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 1.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines support the use of Tramadol (Ultram) for short-term use after there is been evidence of failure of a first-line option, evidence of moderate to severe pain, and documentation of improvement in function with the medication. A review of the available medical records fails to document any improvement in function or pain level with the previous use of Tramadol. As such, the request is not considered medically necessary.

**Flexiril 10 MG #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Chronic Pain Medical Treatment Guidelines 8 C.C.R. .

**Decision rationale:** California Medical Treatment Utilization Schedule Guidelines support the use of skeletal muscle relaxants such as Flexeril for the short-term treatment of pain, but advises against long-term use. Given the injured workers' date of injury and clinical presentation, the guidelines do not support this request for chronic pain. As such, the request is not medically necessary.

**kera ter gel:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

**Decision rationale:** MTUS guidelines state that topical analgesics are "largely experimental" and that "any compound product that contains at least one drug (or drug class) that is not recommended, is not recommended". Additionally, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As such, this request is not considered medically necessary.