

<b>Case Number:</b>	CM14-0106920		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	02/06/2004
<b>Decision Date:</b>	07/03/2015	<b>UR Denial Date:</b>	06/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 55-year-old male, who sustained an industrial injury on February 15, 2001. He reported neck and back pain after driving a forklift on a ramp when the ramp broke causing his neck and back to jar. He also reported back pain while lifting heavy objects from a pallet. The injured worker was diagnosed as having multilevel degenerative disc disease with a history of carpal tunnel release, lumbar laminectomy and discectomy, chronic persistent back pain and right lumbar radiculitis with radicular symptoms of the right lower extremity. Treatment to date has included diagnostic studies, radiographic imaging, lumbar surgery, epidural steroid injections, physical therapy, medications and work restrictions. Currently, the injured worker complains of continued neck and low back pain with right lower extremity radiculitis. The injured worker reported an industrial injury in 2001, resulting in the above noted pain. He was treated conservatively and surgically without complete resolution of the pain. It was noted he had a previous industrial injury to the lower back and hand. Following treatments for the previous injuries, it was noted he placed self-imposed work restrictions. Evaluation on November 4, 2014, revealed continued pain as noted with associated right lower extremity radicular symptoms and poor sleep. He was encouraged to continue a home exercise program. Medications were requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultracet 37.5/325mg, #200 with 1 refill:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20-9792.26 MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120 of 127.

**Decision rationale:** Regarding the request for Ultracet, California Pain, Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Ultracet is not medically necessary.

**Ibuprofen 800mg, #200 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ibuprofen, NSAIDS (Non-Steroidal Anti-Inflammatory Drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20-9792.26 MTUS (Effective July 18, 2009) Page(s): 67-72 of 127.

**Decision rationale:** Regarding the request for ibuprofen, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that ibuprofen is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale) or any objective functional improvement. In the absence of such documentation, the currently requested ibuprofen is not medically necessary.

**Skelaxin 800mg, #200 with 1 refill:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20-9792.26 MTUS (Effective July 18, 2009) Page(s): 63-66 of 127.

**Decision rationale:** Regarding the request for Skelaxin, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the medication. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested Skelaxin is not medically necessary.

**One repeat Trigger point injection:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20-9792.26 Page(s): 122.

**Decision rationale:** Regarding the request for trigger point injections, Chronic Pain Medical Treatment Guidelines support the use of trigger point injections after 3 months of conservative treatment provided trigger points with twitch response as well as referred pain upon palpation are present on physical examination. Repeat trigger point injections may be indicated provided there is at least 50% pain relief with objective functional improvement for 6 weeks. Within the documentation available for review, there are no physical examination findings consistent with trigger points as outlined above. Additionally, there is no documentation of at least 50% pain relief with objective functional improvement for 6 weeks as a result of previous trigger point injections. In the absence of such documentation, the requested trigger point injections are not medically necessary.