

<b>Case Number:</b>	CM14-0203831		
<b>Date Assigned:</b>	12/16/2014	<b>Date of Injury:</b>	07/14/2011
<b>Decision Date:</b>	03/16/2015	<b>UR Denial Date:</b>	12/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2014

### 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, New York, Florida

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease, Critical Care Medicine

### 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 28-year-old male who reported an injury on 07/14/2011. The mechanism of injury was the injured worker was walking out of a strawberry room while carrying a 15 pound tray of strawberries and slipped backwards and the injured worker's foot slipped backwards. Prior therapies included physical therapy and medications. The injured worker underwent urine drug screens. The documentation of 05/29/2014 revealed the injured worker was utilizing tramadol ER 300 mg per day and had no side effects. The injured worker indicated he continued to have low back pain. The surgical history included a lumbar decompression in 03/2013. The injured worker reported improved range of motion with medications and activities of daily living maintained with medication on board including grocery shopping, bathing, grooming, household duties such as preparation of food and taking out the trash. The injured worker indicated the pain had a diminution of 5 - 6 points on the scale of 10, and the injured worker had a further decrease of 3 points on a scale of 10 with NSAIDs. The injured worker had a history of GI upset without PPI and a PPI daily dosing and with twice a day dosing and at 3 times a day dosing there was no GI upset. The spasms remained refractory to heat, cold, stretching, physical therapy, home exercises, activity modification, and a TENS unit. The injured worker indicated orphenadrine decreased muscle spasms. The diagnoses included neurological deficit, L4-5, objectified, reactive depression and status post lumbar decompression in 03/2013. The objective findings revealed tenderness in the lumbar spine. Range of motion was limited. The treatment plan included continue with medications. Additionally, there was

documentation indicating the injured worker should have additional postoperative physical therapy for the lumbar spine. There was no documentation of a recent surgical intervention.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Tramadol 150MG #60:** Upheld

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, objective decrease in pain and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker met the above criteria; however, the request as submitted failed to indicate the frequency for the requested medication. Additionally, the request as submitted failed to provide documentation indicating the requested date of service. Given the above, the request for tramadol 150 mg #60 is not medically necessary.

**Naproxen Sodium 550mg #90:** Upheld

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDS are recommended for short term symptomatic relief of low back pain. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review indicated the injured worker had an objective improvement in function and an objective decrease in pain; however, the request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for naproxen sodium 550 mg #90 is not medically necessary.

**Cyclobenzabrine 7.5MG #90:** Upheld

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker had utilized the medication for an extended period of time. There was a lack of documentation indicating a necessity for exceeding guideline recommendations of 3 weeks. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for cyclobenzaprine 7.5 mg #90 is not medically necessary.