

<b>Case Number:</b>	CM15-0191900		
<b>Date Assigned:</b>	10/05/2015	<b>Date of Injury:</b>	05/07/2009
<b>Decision Date:</b>	12/08/2015	<b>UR Denial Date:</b>	09/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2015

### 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: Preventive Medicine, Occupational 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 48 year old male who sustained an industrial injury on 05-07-2009. A review of the medical records indicated that the injured worker is undergoing treatment for displacement of the lumbar intervertebral disc without myelopathy, chronic low back pain and enthesopathy of the right hip. According to the treating physician's progress report on 09-08-2015, the injured worker continues to experience right lumbar and right hip pain. The injured worker ambulated with an antalgic gait on the right. Deep tendon reflexes and sensation were intact in the bilateral upper and lower extremities. Recent lumbar spine magnetic resonance imaging (MRI) performed on 08-12-2015 with official report was included in the review and interpreted by the treating physician's progress report on 09-08-2015 as "a 4mm and 3 mm protrusion of the L2-L3 and L3-L4 regions". Prior treatments have included diagnostic testing, chiropractic therapy, physical therapy, home exercise program, psychological evaluation and medications. Current medications were listed as Tramadol (over a year on medication), Cyclobenzaprine (since approximately 10-2014) and Naproxen. Treatment plan consists of continuing with home exercise program and Cyclobenzaprine 10mg #60 with 3 refills, Tramadol 50mg #60 with 3 refills, one right hip magnetic resonance imaging (MRI) and one orthopedic referral. On 09-18-2015 the Utilization Review modified the request for Tramadol 50mg # 60 with 3 refills to Tramadol 50mg #40 and determined the requests for Cyclobenzaprine 10mg #60 with 3 refills, one right hip magnetic resonance imaging (MRI) and one orthopedic referral were not medically necessary.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Cyclobenzaprine 10 mg #60 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**Decision rationale:** MTUS Guidelines do not recommend the long term use of muscle relaxants for the treatment of chronic pain disorders and includes there use a sleep aid. The Guidelines specifically state that the use of Cyclobenzaprine should be limited to 3 weeks. If there is significant benefit, short term episodic use for flare-ups may be reasonable, but this is being prescribed and utilized on a daily basis. There are no unusual circumstances to justify an exception to the Guideline recommendations. The Cyclobenzaprine 10 mg #60 with 3 refills is not medically necessary.

**Tramadol 50 mg #60 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional improvement measures, Opioids, criteria for use.

**Decision rationale:** MTUS Guidelines have very specific recommended criteria to support the use of opioid medications. These criteria include detailed documentation of how much pain relief is experienced, how long the pain relief lasts and what are the functional benefits due to opioid use. These standards are not met by the prescribing physician. There is no documentation regarding the level of pain relief and scant documentation of any functional benefits. Under these circumstances, the Tramadol 50 mg #60 with 3 refills is not supported by Guidelines and is not medically necessary. Additional up to date documentation could affect this recommendation.

**One (1) orthopedic referral:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation.

**Decision rationale:** MTUS Guidelines support specialty referral in the diagnosis and treatment of a particular problem is outside the expertise or comfort level of a treating health practitioner.

In this specific incidence there are significant complaints of hip discomfort, yet little in the way of a detailed exam or diagnosis. This appears to be secondary to a lack of skill in evaluating this area which strongly supports the requested referral. The one orthopedic referral is medically necessary.

**One (1) MRI of the right hip:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis/Magnetic Resonance Imaging.

**Decision rationale:** MTUS Guidelines do not address this issue. ODG Guidelines address this issue in detail and the Guidelines recommend at least an examination and plain films prior to MRI studies. In addition, Guidelines recommend special protocols if a labrum tear is suspected and the requesting provider does not provide for any differential diagnosis. An orthopedic consult has been recommended and this appears to be the appropriate venue for requesting diagnostic test under these circumstances. The request for the one MRI of the right hip does not meet Guideline standards and is not medically necessary.