

<b>Case Number:</b>	CM15-0020464		
<b>Date Assigned:</b>	02/10/2015	<b>Date of Injury:</b>	08/28/2012
<b>Decision Date:</b>	03/26/2015	<b>UR Denial Date:</b>	01/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2015

### 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 47 year old male, who sustained an industrial injury on 8/28/2012. He has reported a motor vehicle accident with back pain. The diagnoses have included chronic lumbar pain, degenerative disc disease, and radiculopathy. Treatment to date has included Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), physical therapy, chiropractic care, and selective nerve root block. Currently, the IW complains of back pain radiating into bilateral lower extremities rated 7/10. On 1/29/15, physical examination documented tenderness to palpation to lumbar spine, decreased Range of Motion (ROM), decreased sensation in left L5 dermatome, with Magnetic Resonance Imaging (MRI) from 1/9/15 revealing annular tear left L4-5, posterolateral disc/osteophytes complex L5-S1, and facet arthropathy to L3-L5. The plan of care included transforaminal epidural steroid injection to L5-S1 and to continue medications as previously prescribed. He has uncontrolled pain without medications and the periodic use of Norco allows him to get some office work done. On 1/20/2015 Utilization Review non-certified Cyclobenzaprine 10mg #60, modified certification for Tramadol 50mg #60 and Norco 10/325mg #15, and did approve Ibuprofen 800mg #90. The MTUS Guidelines were cited. On 2/3/2015, the injured worker submitted an application for IMR for review of Cyclobenzaprine 10mg #60, Ibuprofen 800mg #90, Tramadol 50mg #120, and Norco 10/325mg #30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cyclobenzaprine 10mg QTY: 60.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 64-66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 64.

**Decision rationale:** MTUS Guidelines are very specific recommending that Cyclobenzaprine use be limited to 2-3 weeks at a time, it is not recommended for long term chronic use. There are no unusual circumstances to justify and exception to Guidelines. The Cyclobenzaprine 10mg #60 is not supported by Guidelines and is not medically necessary.

**Tramadol 50mg QTY: 120.00:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 93, 94, 113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80.

**Decision rationale:** The MTUS Guidelines allow for judicious use of opioids when there is pain relief and functional improvements as a result of use. It is documented that that he experiences meaningful relief and improved function as a result of use. There are no aberrant drug related behaviors or accelerated use. Under these circumstances, the Tramadol 50mg. #120 is supported by Guidelines and is medically necessary.

**Norco 10/325mg QTY: 30.00:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain Page(s): 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80.

**Decision rationale:** The MTUS Guidelines allow for judicious use of opioids when there is pain relief and functional improvements as a result of use. It is documented that that he experiences meaningful relief and improved function as a result of use. There are no aberrant drug related behaviors or accelerated use. Under these circumstances, the Norco 10/325mg #30 is supported by Guidelines and is medically necessary.