

<b>Case Number:</b>	CM15-0048739		
<b>Date Assigned:</b>	03/20/2015	<b>Date of Injury:</b>	02/07/2013
<b>Decision Date:</b>	05/11/2015	<b>UR Denial Date:</b>	02/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/16/2015

### 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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 57-year-old male who reported an injury on 02/07/2013. The mechanism of injury was gradual onset of pain in the bilateral upper extremities. Prior therapies and treatment included physical therapy and medications. The prior medications included fenoprofen 400 mg, omeprazole 20 mg, eszopiclone 1 mg, and cyclobenzaprine hydrochloride, as well as tramadol ER 150 mg. The documentation of 01/22/2015 revealed the injured worker had constant pain in the cervical spine that was aggravated by repetitive motion. The pain was a 7/10. The injured worker had intermittent pain in the bilateral shoulders which was a 3/10. The physical examination revealed palpable paravertebral muscle tenderness with spasms. The injured worker had a positive axial loading compression test and a positive Spurling's. There was associated numbness and tingling in the lateral forearm and hand. The injured worker had tenderness in the anterior glenohumeral region and subacromial space. The diagnosis included joint derangement NOS, shoulder status post surgery, and cervicalgia. The treatment plan included a refill of the medications. The documentation indicated the injured worker was benefitting from the medications and additionally, the request was made for a course of physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Fenoprofen Calcium (Nalfon) 400mg #120: Upheld**

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend NSAIDs for the short term symptomatic relief of mild to moderate pain. 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 previously utilized the medications. There was a lack of documentation of objective functional improvement and an objective decrease in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for fenoprofen calcium Nalfon 400 mg #120 is not medically necessary.

**Omeprazole 20mg #120: Upheld**

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend proton pump inhibitors for injured workers at intermediate risk or higher for gastrointestinal events. They are also recommended for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review indicated the injured worker had utilized the medication for an extended duration of time. There was a lack of documented efficacy. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for omeprazole 20 mg #120 is not medically necessary.

**Cyclobenzaprine Hydrochloride 7.5mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC) Pain Procedure Summary updated 1/19/15.

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

**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. 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 duration of time. The efficacy was not provided. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for cyclobenzaprine hydrochloride 7.5 mg #120 is not medically necessary.

**Tramadol ER 152mg #90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend opioids for the treatment of chronic pain. There should be documentation of objective functional improvement, an 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 failed to indicate the injured worker had objective functional improvement and an objective decrease in pain. There was a lack of documentation indicating the injured worker was being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for tramadol ER 152 mg #90 is not medically necessary. Additionally, there is no strength that is 152 mg; however, this was not a determining factor in the denial.

**Eszopiclone 1mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Pain Procedure Summary last update 1/19/15.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Eszopiclone.

**Decision rationale:** The Official Disability Guidelines indicate that eszopiclone is recommended for the short-term treatment of insomnia for up to 10 days. There was a lack of documentation indicating the injured worker had insomnia. There was a lack of documented rationale for this request. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for eszopiclone 1 mg #30 is not medically necessary.