

<b>Case Number:</b>	CM15-0056031		
<b>Date Assigned:</b>	04/01/2015	<b>Date of Injury:</b>	11/14/2011
<b>Decision Date:</b>	05/15/2015	<b>UR Denial Date:</b>	03/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/24/2015

### 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: 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 58-year-old male who reported injury on 11/14/2011. The mechanism of injury was not provided. There was a Request for Authorization submitted for review for the medications dated 03/06/2015. The documentation of 01/06/2015 revealed the injured worker had severe low back pain and constant pain in the cervical spine, and right shoulder and frequent pain in the bilateral feet, wrists, and hands. The physical examination of the cervical spine revealed palpable paravertebral muscle tenderness with spasm and a positive axial loading compression test with extension of symptomatology in the upper extremities. The injured worker had a well healed scar on the right shoulder. There was tenderness at the right shoulder anteriorly. There was limited range of motion and residual weakness. There was tenderness in the volar aspect of the bilateral wrists. The Tinel's sign was positive, as was the Palmer compression test and Phalen's maneuver bilaterally. There was palpable paravertebral muscle tenderness with spasms in the lumbar spine. The seated nerve root test was positive. There was pain and tenderness in the heel cord as well as the plantar aspect of the bilateral feet. The diagnoses included cervical discopathy, lumbar discopathy/segmental instability, status post right shoulder replacement 08/16/2013, bilateral carpal tunnel syndrome/double crush syndrome and bilateral plantar fasciitis. The treatment plan included awaiting the epidural steroid injection and request for the medications. The MRI of the lumbar spine dated 10/20/2014 revealed a mottled appearance of the lumbar vertebrae. The physician opined this may be nonspecific however could indicate osteopenia and/or marrow infiltrative disorder. There was mild wedging of L1, there was a 1 cm anterolisthesis of L5 on S1. There was increased left signal in the

posterior paravertebral musculature particularly at L5-S1 level consistent with fatty change and atrophy. There was a probable pars defect at L5. There were multilevel disc changes. Omeprazole was noted to be prescribed for the injured worker's GI symptoms, cyclobenzaprine for palpable muscle spasms, tramadol for acute severe pain, and Nalfon for inflammation and pain.

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

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

**Decision rationale:** The California MTUS guidelines indicate that NSAIDS are recommended for 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 failed to provide 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) 400mg #120 is not medically necessary.

#### **Omeprazole 20mg #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend proton pump inhibitors for injured workers at intermediate risk or higher for gastrointestinal events. The clinical documentation submitted for review indicated the injured worker was being given omeprazole due to GI symptoms, however, there was a lack of documentation of efficacy for the requested medication. It was indicated the injured worker had previously utilized the medication. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documentation indicating the injured worker was at intermediate or higher risk for gastrointestinal events. Given the above, the request for Omeprazole 20mg #120 is not medically necessary.

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

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

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

**Decision rationale:** The California MTUS guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain, less than 3 weeks and there should be documentation of objective functional improvement. The clinical documentation submitted for review failed to provide exceptional factors to warrant non-adherence to guideline recommendations. There was a lack of documented objective functional improvement. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Cyclobenzaprine Hydrochloride 7.5mg #120 is not medically necessary.

**Tramadol ER 150mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management, opioid dosing Page(s): 60, 78, 86.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The cumulative dosing of all opiates should not exceed 120 mg oral morphine equivalents per day. The clinical documentation submitted for review failed to provide documentation of an objective decrease in pain, objective functional improvement, and documentation the injured worker was being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate frequency for the requested medication. Given the above, the request for Tramadol ER 150mg #90 is not medically necessary.

**LESI (unspecified):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend epidural steroid injections for patients who have documented objective findings upon examination of radiculopathy that are corroborated by electrodiagnostic or imaging findings. There should be documentation of a failure of conservative care including exercise, muscle relaxants, physical therapy, and NSAIDs. The clinical documentation submitted for

review failed to provide documentation of the above criteria. There was a lack of documentation of objective findings radiculopathy upon physical examination. The request as submitted failed to indicate the level and the laterality. Given the above, the request for LESI unspecified is not medically necessary.