

<b>Case Number:</b>	CM14-0142490		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	05/15/2008
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	08/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/03/2014

### 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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 56-year-old female with a 5/15/08 date of injury, when he lifted some boxes. A UR review dated 8/8/14 stated that requested medications were not found medically necessary. Progress note dated 4/22/14 described complaints of low back pain with spasms, slight swelling, and positive SLR. 7/8/14 Progress note described lumbar spasms, reduced range of motion with pain, and negative SLR. 8/12/14 Progress note described low back pain, worse with weight gain. Clinically, there was increased spas and positive right leg raising. Medication refill was requested. Treatment to date has included activity modification and medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone/APAP 10-325mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-80.

**Decision rationale:** Medical necessity for the requested medication is not established. The patient has a 2008 date of injury; however there is no discussion regarding efficacy of the prescribed medications. The California MTUS requires documentation of ongoing review and

documentation of pain relief, functional status, appropriate medication use, and side effects. There is no discussion of assessment of compliance with the use of random drug screens or a pain contract. Therefore, this request is not medically necessary.

**Nabumetone 500mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Short-Term Symptomatic Relief Page(s): 47.

**Decision rationale:** Medical necessity for the requested NSAID is not established. This medication is generally indicated for osteoarthritic or inflammatory pain. Duration of use, functional improvement, or pain reduction has not been discussed. The California MTUS states that NSAIDs are effective; however chronic use may lead to gastric side effects. Chronic use must outweigh risk of adverse effects. Therefore, this request is not medically necessary.

**Nortriptyline 50mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants Page(s): 13-14.

**Decision rationale:** Medical necessity for the requested antidepressant has not been established. Although this medication is considered by the California MTUS as a first line treatment option for neuropathic pain, there is no discussion regarding continued efficacy of this medication. There is no discussion regarding functional improvement, or documentation of any psychological issues. Duration of use has not been discussed. Therefore, this request is not medically necessary.

**Tizanidine 4mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics, Antispasticity Drugs Page(s): 63.

**Decision rationale:** Medical necessity has not been established for the requested medication. The California MTUS Chronic Pain Medical Treatment Guidelines recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. However, chronic use is not guideline supported. There is no indication of an acute exacerbation, and continued efficacy has not been discussed. Therefore, this request is not medically necessary.

