

Case Number:	CM14-0143193		
Date Assigned:	09/10/2014	Date of Injury:	03/11/2011
Decision Date:	10/29/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	09/04/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 53 year old female with a work injury dated 3/11/11. The diagnoses include cervical disc disease with radiculopathy. Under consideration is a request for Cyclobenzaprine Hydrochloride Tablets 7.5mg #120; Omeprazole Delayed-Release Capsules 20mg #120; Tramadol Hydrochloride ER 150mg #90. There is a primary treating physician report dated 07/15/14 that states that there was constant pain in the cervical spine that was aggravated by repetitive motions of the neck, pushing, pulling, lifting, forward reaching and working at or above the shoulder level. The pain was dull and there was radiation of pain into the upper extremities. There were associated headaches that were migrainous as well as pain below the shoulder blades. The patient's pain was unchanged. The pain rate was 2/10. There was constant pain in the low back that was aggravated by bending, lifting, twisting, pushing, pulling, prolonged sitting and standing, and walking multiple blocks. The pain was unchanged. The pain was rated 6/10. On physical exam the gait was intact. The cervical spine revealed the patient's gait was intact. The Spurling's maneuver was negative. The range of motion (ROM) was limited with pain. On physical exam of the lumbar spine, there was palpable paravertebral muscle tenderness with spasm. The seated nerve root test was positive. The range of motion in lumbar motion was guarded and restricted in flexion and extension. The treatment plan included a refill of medications and a return to modified work.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine Hydrochloride Tablets 7.5mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for Pain) Page(s): Pages 63-64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) ; Antispasmodics Page(s): 41-42; 6.

Decision rationale: Per the MTUS Chronic Pain Guidelines this medication is not recommended to be used for longer than 2-3 weeks. From the documentation submitted patient has been on Cyclobenzaprine long term. The guidelines do not support this medication for long term use; therefore Cyclobenzaprine Hydrochloride Tablets 7.5mg #120 are not medically necessary.

Omeprazole Delayed-Release Capsules 20mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): Pages 70-71.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

Decision rationale: There is no history that patient meets MTUS criteria for a proton pump inhibitor including : (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The MTUS Chronic Pain Guidelines do not support treatment Proton Pump Inhibitor medication in the absence of symptoms or risk factors for gastrointestinal disorders. As such, the request is not medically necessary and appropriate.

Tramadol Hydrochloride ER 150mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): Pages 78-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management; When to Discontinue Opioids; Opioids, pain treatment agreement Page(s): 78;. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Functional Restoration Approach to Chronic Pain Management page 8

Decision rationale: The documentation indicates that Tramadol is indicated for moderate to severe pain. The documentation indicates that the patient is working modified duty. The documentation indicates that the patient has used Tramadol in episodes of flare up for severe pain. The documentation The MTUS states that demonstration of functional improvement is necessary at various milestones in the functional restoration program in order to justify continued treatment. The request for a quantity of #90 is not medically necessary as the patient may need to be monitored for evidence of continued function and analgesia to justify continuing this

medication. The request for Tramadol Hydrochloride ER 150mg #90 is not medically necessary as written.