

<b>Case Number:</b>	CM14-0144228		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	12/05/2012
<b>Decision Date:</b>	10/28/2014	<b>UR Denial Date:</b>	08/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/05/2014

### 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 Internal Medicine and is licensed to practice in New York. 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 claimant is a 54 yo female who sustained an industrial injury on 12/05/2012. The mechanism of injury was not provided for review. Her diagnoses include neck pain, low back pain, right shoulder pain, headaches, and bilateral ankle pain. She complains of neck and low back pain (8/10) that is aggravated by pushing, pulling, lifting, forward reaching and working above the shoulder level. On physical exam the patient has an antalgic gait with decreased range of motion of the cervical spine with paravertebral muscle tenderness with spasm. A positive axial loading compression test was positive and the Spurling's test was positive. Examination of the lumbar spine revealed decreased range of motion with paravertebral muscle tenderness with spasm. There was tingling and numbness in the lateral thigh, anterolateral and posterior leg as well as foot, L5 and S1 dermatomal patterns. Strength was 4/5 in the extensor hallucis longus and ankle flexors, L5 and S1 innervated muscles. Examination of the right shoulder revealed pain with range of motion and the Hawkins and impingement signs were positive. Examination of the ankles revealed tenderness to palpation over the anterior portion of the ankles. Treatment has included medical therapy with Voltaren SR, Tramadol, Cyclobenzaprine, Omeprazole, Sumatriptan, Ondansetron, Norco, Ketoprofan, Mentoderm gel, Terocin patch and Quazepam. The treating provider has requested Cyclobenzaprine 7.5mg tid # 120, and Tramadol ER qd # 90.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CYCLOBENZAPRINE HYDROCHLORIDE TAB 7.5MG #120 1 PO Q8HRS PRN:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines California MTUS 2009 Page(s): 41.

**Decision rationale:** Per the reviewed literature, Cyclobenzaprine is not recommended for the long-term treatment of cervical pain. The medication has its greatest effect in the first four days of treatment. The documentation does indicate there are palpable muscle spasms but there is no documentation of functional improvement from any previous use of this medication. The patient has been treated with multiple medical therapies. Per CA MTUS Guidelines muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. Based on the currently available information, the medical necessity for chronic use of this muscle relaxant medication has not been established. The requested item is not medically necessary.

**TRAMADOL ER #90 ONCE A DAY PRN:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines California MTUS 2009 Page(s): 93, 94-96.

**Decision rationale:** The review of the medical documentation indicates that the requested medication, Ultram 50 mg is not medically necessary and indicated for the treatment of the claimant's chronic pain condition. Per California MTUS, Ultram (Tramadol) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation there has been no documentation of the medication's pain relief effectiveness and no clear documentation that he has responded to ongoing opioid therapy. According to the California MTUS Guidelines there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. In addition, the documentation provided is lacking of California MTUS Opioid compliance guidelines including risk assessment profile, attempts at weaning/tapering, updated urine drug screen, updated efficacy, and an updated signed patient contract between the provider and the claimant. Medical necessity for the requested item has not been established. The requested treatment is not medically necessary.

