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| <b>Case Number:</b>   | CM15-0001980 |                              |            |
| <b>Date Assigned:</b> | 01/13/2015   | <b>Date of Injury:</b>       | 03/23/2010 |
| <b>Decision Date:</b> | 03/12/2015   | <b>UR Denial Date:</b>       | 12/29/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/05/2015 |

### 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 44-year-old male who reported an injury on 03/23/2010. The mechanism of injury was not provided. On 12/16/2014, the injured worker presented with complaints of pain in the mid back and below the shoulder blades. Diagnoses were thoracic degenerative disc disease, myofascial pain, abnormal weight gain, HTN (not otherwise specified otherwise specified), and insomnia. Upon examination, there was tenderness to palpation over the mid thoracic and parascapular with hypertonicity over the thoracic and lumbar paraspinal musculature. The treatment plan included a refill of naproxen, omeprazole, and cyclobenzaprine, with a continued home exercise program and TENS. The Request for Authorization form was dated 12/16/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of TENS Page(s): 116.

**Decision rationale:** The request for a decision for TENS unit is not medically necessary. The California MTUS Guidelines do not recommend a TENS unit as a primary treatment modality. A 1 month home based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence based functional restoration. There was a lack of documentation indicating significant deficits upon physical examination. The efficacy of the injured worker's previous courses of conservative care were not provided. There is no evidence on if the injured worker underwent an adequate TENS trial. The request was also unclear as to if the injured worker needed to rent or purchase a TENS unit and for which body it was intended. As such, medical necessity has not been established.

**Tramadol 50mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

**Decision rationale:** The request for tramadol 50 mg with a quantity of 90 is not medically necessary. The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There was a lack of documentation of an objective assessment of the injured worker's pain level, functional status, appropriate medication use, and side effects. There is no information on treatment history and length of time the injured worker has been prescribed tramadol. There was no evidence of an increased function or decreased pain with prior use of the medication to support continued use. A current urine drug screen and a current signed pain contract was not submitted for review. As such, medical necessity has not been established.

**Cyclobenzaprine 7.5mg #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 Cyclobenzaprine (Flexeril) Page(s): 41.

**Decision rationale:** The request for cyclobenzaprine 7.5 mg with a quantity of 60 is not medically necessary. The California MTUS recommends cyclobenzaprine as an option for a short course of therapy. The great effect of this medication is in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. The request for cyclobenzaprine 7.5 mg with a quantity of 60 would exceed the guideline recommendation of short term therapy. There was also no information on treatment history and length of time the

injured worker has been prescribed cyclobenzaprine. The provided medical records lacked documentation of significant objective functional improvement. The provider's rationale for the request was not submitted within the documentation. Additionally, the providers request did not indicate the frequency of the medication in the request as submitted. As such, medical necessity has not been established.