

<b>Case Number:</b>	CM14-0148807		
<b>Date Assigned:</b>	09/18/2014	<b>Date of Injury:</b>	02/25/2011
<b>Decision Date:</b>	10/22/2014	<b>UR Denial Date:</b>	08/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/12/2014

### 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 and Rehabilitation, and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 58-year-old female who reported an injury on 02/25/2011 after an explosion occurred on the bus she was driving. The injured worker reportedly sustained an injury to her shoulder and knee. The injured worker's treatment history included physical therapy, injections, multiple medications, surgical intervention, and postoperative therapy. The injured worker was evaluated on 04/31/2014. Objective findings included tenderness of the lateral joint line of the right knee with weakness to resisted function and range of motion described as 180 degrees in extension and 120 degrees in flexion. The injured worker's diagnoses included chronic right knee pain, multilevel lumbar disc disease with facet arthrosis, discogenic cervical condition, right shoulder impingement, bilateral carpal tunnel syndrome, and insomnia and depression. The injured worker's treatment plan included x-rays of the knee, and continuing medications to include Flexeril 7.5 mg, naproxen 550 mg, Neurontin 600 mg, and Tramadol 150 mg. The injured worker was also prescribed Valium 10 mg to assist with sleeping. No Request for Authorization form was submitted to support the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flexeril 7.5mg #60:** Upheld

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule recommends short durations of treatment, not to exceed 2 to 3 weeks, for acute exacerbations of chronic pain. The clinical documentation submitted for review does not provide any indication that the patient has previously been treated with a muscle relaxer. Therefore, a short course of treatment would be supported. However, the request as it is submitted does not clearly identify duration of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

**Naproxen 550mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anit-Inflammatory medicine (NSAIDs) Page(s): 22.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain and NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 60; 67.

**Decision rationale:** The California Medical Treatment Utilization Schedule does recommend the use of nonsteroidal anti-inflammatory drugs to assist with chronic pain. However, California Medical Treatment Utilization Schedule states that any medication use in the management of chronic pain be supported by documented functional benefit and pain relief. The clinical documentation submitted for review does not provide any evidence of an adequate pain assessment to support the efficacy of this medication. Additionally, there is no documentation of significant functional benefit to support the use of this medication. Furthermore, the request as it is submitted does not clearly define duration of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

**Neurontin 600mg #90:** 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 Antiepilepsy drugs (AEDs) Page(s): 16.

**Decision rationale:** The California Medical Treatment Utilization Schedule recommends the ongoing use of anticonvulsants in the management of chronic pain be supported by at least a 30% pain relief and documented functional benefit. The clinical documentation submitted for review does not provide any evidence that the injured worker has any significant pain relief or functional benefit resulting from medication usage. Therefore, continued use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of

treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

**Valium 10mg #30:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Insomnia Treatment

**Decision rationale:** The California Medical Treatment Utilization Schedule does not address this medication as an insomnia treatment. Official Disability Guidelines recommend benzodiazepines to assist with sleep restoration for short durations of treatment. The clinical documentation submitted for review does indicate that the patient is unable to sleep for more than 1 hour per night and has failed to respond to a sedating antidepressant. Therefore, a short course of treatment with this medication would be supported in this clinical situation. However, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

**Tramadol ER 150mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines tramadol (Ultram) Page(s): 113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

**Decision rationale:** The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence of significant pain relief or functional benefit resulting from the use of this medication. Furthermore, there is no documentation that the patient is monitored for aberrant behavior or is engaged in a pain contract. Therefore, continued use of this medication would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.