

<b>Case Number:</b>	CM13-0025346		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	11/01/2012
<b>Decision Date:</b>	04/10/2014	<b>UR Denial Date:</b>	09/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2013

### 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 Neuromusculoskeletal Medicine, and is licensed to practice in Arizona. 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 31-year-old male with history of an injury to his neck, back and shoulders when he was drying a vehicle while working at a car wash. Based on the primary treatment physician's progress report on May 8, 2013 the date of injury occurred in Aug of 2011 but on the MAXIMUS requested documents the date of injury occurred on 11/1/12. Since then, the patient has complained of neck, back and shoulder pain. On physical examination, from the primary treatment physicians progress report on Aug 28, 2013, the patient had a restriction of his cervical range of motion bilaterally with concomitant paravertebral muscle spasm, tenderness, tight muscle band and a trigger point. In his lumbar spine, he has a loss of the normal lordosis with straightening of the lumbar spine, decreased range of motion because of pain with bilateral paravertebral muscle hypertonicity, spasm and tenderness. His neurological examination is negative for any form of neurological compromise in sensory, motor or reflex activity. The progress note from Aug 28, 2013 does document the patient was reporting medication side effect of abdominal pain. His flexeril is documented as use for night time.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**30 FLEXERIL 10MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-INFLAMMATORY MEDICATION.

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

**Decision rationale:** Cyclobenzaprine (Flexeril®) is recommended as an option, using a short course of therapy. See Medications for chronic pain for other preferred options. Cyclobenzaprine (Flexeril®) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief. With the areas of chief complaint ongoing since initial injury in November of 2012, the window for appropriate use of this medication has elapsed. I find that it is not medically necessary.

**60 IBUPROFEN 800MG WITH 1 REFILL:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAID)'S.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 22, 67-68.

**Decision rationale:** Anti-inflammatory medications For specific recommendations, see NSAIDs (non-steroidal anti-inflammatory drugs). Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. (Van Tulder-Cochrane, 2000) A comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of low back pain concludes that available evidence supports the effectiveness of non-selective non-steroidal anti-inflammatory drugs (NSAIDs) in chronic low back pain (LBP) and of antidepressants in chronic LBP. (Schnitzer, 2004) See also Nonprescription Medications. COX-2 inhibitors (e.g., Celebrex) may be considered if the patient has a risk of gastrointestinal (GI) complications, but not for the majority of patients. Generic NSAIDs and COX-2 inhibitors have similar efficacy and risks when used for less than 3 months, but a 10-to-1 difference in cost. NSAIDs (non-steroidal anti-inflammatory drugs) Back Pain - acute exacerbations of chronic pain: recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute LBP. (van Tulder, 2006) (Hancock, 2007) For patients with acute low back pain with sciatica a recent Cochrane review (including three heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs vs. placebo. In patients with axial low back pain this same review found that NSAIDs were not more effective than acetaminophen for acute low back pain, and that acetaminophen had fewer side effects. Back Pain - Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. Based upon the MTUS recommendations, NSAIDs are for short term (not specified as to length of time) for pain reduction for either acute or chronic low back

pain. As the patient is nearly 18 months post injury with continued complaint of low back pain, I find that the requested treatment regimen is not medically necessary.