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| <b>Case Number:</b>   | CM13-0048965 |                              |            |
| <b>Date Assigned:</b> | 12/27/2013   | <b>Date of Injury:</b>       | 04/26/2013 |
| <b>Decision Date:</b> | 04/25/2014   | <b>UR Denial Date:</b>       | 10/11/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/06/2013 |

### 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 Internal Medicine, has a subspecialty in Pulmonary Diseases, and is licensed to practice in California. 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 54-year-old who reported an injury on April 26, 2013, after he was pushing a heavy machine, which reportedly caused injury to his low back. The patient was initially treated with physical therapy, hydrocodone, cyclobenzaprine, and ibuprofen. The patient's most recent clinical documentation noted that the patient had a history of gastritis-type symptoms with anti-inflammatory medications. The patient's most recent clinical documentation noted that the patient had decreased lumbar range of motion secondary to pain, with decreased sensation to light touch in the dorsal aspect of the right foot, and decreased reflexes in the right ankle. It was also noted that the patient had decreased strength with the right dorsiflexion and right extensor hallucis longus muscle. The patient's diagnoses included right lumbosacral strain, right lumbosacral radiculopathy, and myofascial pain. The patient's treatment plan included naproxen 550 mg, omeprazole 20 mg, and Neurontin 600 mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DENDRACIN LOTION 120 ML:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111.

**Decision rationale:** The requested medication is a compounded topical agent that contains methyl salicylate, menthol, and capsaicin. The Chronic Pain Medical Treatment Guidelines recommends the use of menthol and methyl salicylate for patients who have osteoarthritic-related pain. The clinical documentation submitted for review does not support that the patient's pain is osteoarthritic in nature. Additionally, California Medical Treatment Utilization Schedule does not support the use of capsaicin as a topical analgesic unless the patient has failed to respond to other first-line analgesics such as anticonvulsants and antidepressants. The clinical documentation does indicate that the patient is taking Neurontin. Therefore, the need for a topical analgesic such as capsaicin is not clearly established. The request for Dendracin lotion 120 ml is not medically necessary or appropriate.

**FLEXERIL 7.5 MG 90 COUNT:** Upheld

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

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines does not recommend the use of muscle relaxants for the long-term treatment of low back pain. The Chronic Pain Medical Treatment Guidelines recommends that a duration of treatment be limited to two to three weeks. The clinical documentation submitted for review indicates that the patient has been on this medication since at least May, 2013. Therefore, continued use would not be supported. The request for Flexeril 7.5 mg, 90 count, is not medically necessary or appropriate.

**OMEPRAZOLE 20 MG 30 COUNT:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), GI (gastrointestinal) Symptoms & Cardiovascular.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines recommends a gastrointestinal protectant for patients who are at risk for developing gastrointestinal symptoms related to medication usage. The clinical documentation submitted for review does indicate that the patient has been on a non-steroidal anti-inflammatory drug since at least May of 2013, with documentation of gastric upset related to anti-inflammatory drug usage. Additionally, the clinical documentation does indicate that the patient has a history of gastric reflux. Therefore, the need for a gastrointestinal protectant would be supported by guideline recommendations. The request for Omeprazole 20 mg, 30 count, is medically necessary and appropriate.