

<b>Case Number:</b>	CM13-0049610		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	08/24/2004
<b>Decision Date:</b>	06/05/2014	<b>UR Denial Date:</b>	10/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/08/2013

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management, 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 59-year-old female with a date of injury of August 24, 2004. The listed diagnoses per [REDACTED] are Discogenic lumbar condition with radiculitis down the left lower extremity and facet inflammation treated conservatively with nerve studies being negative, and foot and ankle involvement on the left for which no treatment is being provided and for which there is no coverage. According to report dated October 8, 2013 by [REDACTED], the patient presents with low and midback pain. Objective findings include flexion at 50 degrees and extension at 30 degrees. Reflexes are satisfactory. Grade 5 strength to resisted function is noted. Tenderness along the lumbar sacral area with facet loading is also noted. Her medication regimen includes Norco, naproxen 550 mg, Protonix 20 mg, Flexeril 7.5 mg, and Terocin patches. Progress report August 30, 2013 indicates the patient continues with back pain, which is rated 6/10 on pain scale. Pain radiates to left lower extremity as she has spasm and numbness in the left leg. Treater reviews diagnostic studies including an MRI of the lumbar spine from April 19, 2013 that showed L4-L5 mild disk height loss and desiccation, 2 mm broad-based disk bulge, effacement of the thecal sac, slightly tightening of the caudal aspect of the foramen. Treater would like to request authorization for back brace and hot and cold wrap and refill of medications. Utilization review denied the request on October 18, 2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NAPROXEN 550 MG FOR NEXT VISIT QTY:60.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms and Cardiovascular Risk, Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications For Chronic Pain Section, NSAIDs (Non-Steroidal Anti-Inflammatory Drugs), Anti-Inflam.

**Decision rationale:** This patient presents with chronic low and midback pain. The treater is requesting naproxen 550 mg #60. For anti-inflammatory medication, the Chronic Pain Medical Treatment Guidelines states "anti-inflammatory 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." In this case, the progress report from April 3 to October 8, 2013 each provides a recommendation for Naproxen for anti-inflammation but there is not one discussion in regards to how naproxen works or does not work. There is no indication that there has been any decrease in pain or improvement in functional activities from taking Naproxen. The Chronic Pain Medical Treatment Guidelines requires pain assessment and functional changes to be documented when medication is used for chronic pain. The request for Naproxen 550 mg for next visit, sixty count, is not medically necessary or appropriate.

**PROTONIX 20 MG FOR NEXT VISIT QTY:60.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms and Cardiovascular Risk Section, Page(s): 68.

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

**Decision rationale:** This patient presents with chronic low to midback pain. The treater is requesting a refill of Protonix 20 mg #60 as a "buffer based on her age and the need for the naproxen." The Chronic Pain Medical Treatment Guidelines states, "Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors." The Chronic Pain Medical Treatment Guidelines recommends determining risk for GI (gastrointestinal) events before prescribing prophylactic PPI or omeprazole. GI risk factors include: (1) Age is greater than 65, (2) History of peptic ulcer disease and GI bleeding or perforation, (3) Concurrent use of ASA or corticosteroid and/or anticoagulant, (4) High dose/multiple NSAID. This patient has been prescribed Prilosec since April 26, 2013 concurrently with Naproxen. Review of reports from April 3 to October 8, 2013 does not provide any discussion of gastric irritation, peptic ulcer history, or concurrent use of ASA, etc. The treater is prescribing this medication as a "buff." Routine prophylactic use of PPI (proton pump inhibitor) without documentation of gastric side effects is not supported by the guidelines without GI-risk assessment. The request for Protonix 20 mg for next visit, sixty count, is not medically necessary or appropriate.

**FLEXERIL 7.5 MG FOR NEXT VISIT QTY: 60.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants for Pain Section..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

**Decision rationale:** This patient presents with chronic low to midback pain. The treater is requesting Flexeril 7.5 mg #60 for patient's spasm. The Chronic Pain Medical Treatment Guidelines states that "cyclobenzaprine is recommended for short course of therapy. Limited mixed evidence does not allow for recommendation for chronic use." Medical records indicate that this patient has not been prescribed. The treater recommends Flexeril for patient's muscle spasms. The Chronic Pain Medical Treatment Guidelines does not recommend long-term use of muscle relaxants and recommends using three to four days of acute spasm and no more than two to three weeks. The request for Flexeril 7.5 mg for next visit, sixty count, is not medically necessary or appropriate.

**TEROCIN PATCHES FOR NEXT VISIT QTY: 30.00:** Overturned

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

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

**Decision rationale:** This patient presents with chronic low to midback pain. The treater is requesting a trial of thirty Terocin patches. Terocin patches contain salicylate, capsaicin, menthol, and lidocaine. The Chronic Pain Medical Treatment Guidelines states under lidocaine, "Indications are for neuropathic pain, recommended for localized peripheral pain after there has been evidence of trial of first line therapy. Topical lidocaine in the formulation of a dermal patch has been designed for orphan status by the FDA for neuropathic pain. Lidoderm is also used off label for diabetic neuropathy." This patient presents with neuropathic pain and the treater recommends a trial of Terocin patches. The request for Terocin patches for next visit, thirty count, is medically necessary and appropriate.

**BACK BRACE QTY:1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition , 2008 Update, Chapter 12, pages 138-139.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Guidelines For Lumbar Supports.

**Decision rationale:** This patient presents with chronic low to midback pain. The treater is requesting authorization for a back brace. The Low Back Complaints Chapter of the ACOEM Practice Guidelines states, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." The ODG guidelines regarding lumbar support

states, "Not recommended for prevention; however, recommended as an option for compression fracture and specific treatment of spondyloisthesis, documented instability, and for treatment of nonspecific low back pain (very low-quality evidence, but may be a conservative option)." In this case, the patient does not present with fracture, instability, or spondylolisthesis to warrant lumbar bracing. The patient does have nonspecific low back pain, but this has very low-quality evidence. The request for one back brace is not medically necessary or appropriate.

**HOLD/COLD WRAP QTY:1.00:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter, and Foot and Ankle Chapter.

**Decision rationale:** This patient presents with chronic low to midback pain. The treater is requesting a hot and cold wrap. Utilization review denied the request stating "guidelines support use of seven days of cold therapy beginning with the day of surgery." The Low Back Complaints Chapter of the ACOEM Practice Guidelines states, "At-home local applications of heat or cold are as effective as those performed by therapists." The ODG guidelines considers cold/heat therapy as a recommended option. In this case, the treater states that cold/heat application has provided pain relief for this patient. ACOEM Guidelines and ODG recommends this modality as an option. The request for one hot/cold wrap is medically necessary and appropriate.