

<b>Case Number:</b>	CM14-0002176		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	04/03/2007
<b>Decision Date:</b>	06/30/2014	<b>UR Denial Date:</b>	12/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2014

### 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 Occupational Medicine 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 52 year old female who was injured on 04/03/2007. The mechanism of injury is unknown. The MRI of the lumbar spine dated 08/22/2013 revealed dextroscoliosis; disc change including posterior disc protrusion 3-4 mm at L5-S1. There is no compression of the traveling nerve roots. There is compromise of the traveling nerve roots. There is compromised of the exiting nerve roots bilaterally. The PR2 dated 11/22/2013 documented the patient had complaints of low back pain. She described the pain as sharp and stabbing in nature and radiating into the right leg mostly at night. She reported numbness, paresthesia, and weakness. The patient is currently disabled and has tried ice, heat, application, NSAIDs and the pain has not improved. The patient has received lumbar steroid epidural injection on 10/28 which decreased her pain by 50%. Objective findings on exam revealed the patient was able to heel-toe walk without difficulty. There is 2+ tenderness to palpation on the right. Atrophy is present in the quadriceps. On forward flexion, the patient is able to reach 10 degrees. Right rotation is diminished as well as left rotation. Straight leg raise test is positive at 40 degrees on the right. Range of motion of the spine is limited secondary to pain. Lower extremity deep tendon reflexes are absent at ankle, sensation to light touch is decreased on the right in the lateral calf, lateral foot, motor strength of the lower extremity measures 5/5 in all groups bilaterally. The patient is diagnosed with low back pain, lumbar disc displacement and lumbar radiculopathy. The treatment and plan included request for authorization for second lumbar steroid injection at L5-S1 level. A Prior UR dated 12/20/2013 states the request for naproxen sodium 550 mg, cyclobenzaprine 7.5mg, #120, omeprazole 20mg, #120, is not medically necessary as there is a lack of documentation to support requests.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NAPROXEN SODIUM 550MG, #100:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, NSAIDs Page(s): 67-72.

**Decision rationale:** The MTUS guidelines recommend NSAIDs for short-term symptomatic treatment of chronic low back pain. They are recommended at the lowest dose for the shortest duration possible for osteoarthritis. There is inconsistent evidence for use of NSAIDs to treat long-term neuropathic pain. The patient is a 52 year old female with chronic low back pain. Medical records to not document functional improvement from prior use of Naproxen nor is duration of use clear. Medical necessity is not established.

**CYCLOBENZAPRINE 7.5MG, #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Cyclobenzaprine (Flexeril; 1/2) Page(s): 63-64, 41-42.

**Decision rationale:** The MTUS guidelines recommend muscle relaxants for short-term treatment of acute exacerbations of chronic low back pain. Long-term use is not recommended. The patient is a 52 year old female with chronic low back pain. Medical records to not document functional improvement from prior use of Cyclobenzaprine nor is duration of use clear. Medical necessity is not established.

**OMEPRAZOLE 20MG, #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, NSAIDs, GI Symptoms and.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, NSAIDs, GI Symptoms and Cardiovascular Risk, Page(s):.

**Decision rationale:** The MTUS guidelines recommend proton pump inhibitors for patients taking NSAIDs at immediate or high risk of gastrointestinal events. The patient is a 52 year old female with chronic low back pain. Medical records to not document moderate to high risk of gastrointestinal events due to NSAID use. Further, medical necessity of Naproxen use is not established. The medical necessity of Omeprazole is not established.