

<b>Case Number:</b>	CM14-0013827		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	04/04/2012
<b>Decision Date:</b>	08/06/2014	<b>UR Denial Date:</b>	01/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2014

### 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:

This is a 41-year-old male with a 4/4/12 date of injury. The mechanism of injury was not noted. In a 1/28/14 progress note, the patient claimed that his pain was a 7/10 on a pain scale of 0-10 with medications. He noted that his pain was located in his bilateral, axial lower back, and he denied radiation of pain into his bilateral lower extremities. He noted that he experienced numbness in his bilateral lower extremities that occur with sitting greater than 2-3 minutes. Objective findings: alert and oriented, patient ambulates without assistance, decreased lumbar range of motion. Diagnostic impression: Lumbar disc displacement without myelopathy, Pain in joint lower leg. Treatment to date includes medication management, activity modification, physical therapy, ESI and TENs unit. A UR decision dated 1/28/14 denied the requests for Diclofenac 1.5% cream, Flexeril and Anaprox. The request for Tramadol/APAP was modified from 90 tablets to 75 tablets for weaning purposes. The Diclofenac cream was denied because of the lack of support for a custom compounded concentration of Diclofenac Sodium, the request is non-certified. Regarding Flexeril, guidelines do not support the long-term use of Cyclobenzaprine and there is no evidence of additional benefit when used in combination with NSAIDs. Regarding Anaprox, the patient has been on it since 7/2013. Guidelines support the short-term use of naproxen for symptomatic relief. Multiple previous requests denied the request as well. Regarding Tramadol/APAP, guidelines do not recommend long-term opioid use and recommend discontinuation in the absence of objective documentation of pain relief and functional improvement. While the provider reports a decrease in pain resulting from medication use, there is no documentation of a detailed ongoing pain assessment or an improvement in examination findings.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DICLOFENAC SODIUM 1.5% CREAM 60 GRM: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

**Decision rationale:** California MTUS states that Voltaren Gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist); and has not been evaluated for treatment of the spine, hip or shoulder. Voltaren gel is a topical gel containing 1% Diclofenac. However, this request is for a custom compounded formulation of a cream containing Diclofenac 1.5%. In addition, there is no documentation in the reports reviewed that the patient has an arthritic condition. A specific rationale identifying why Diclofenac Sodium 1.5% cream would be required in this patient despite guideline recommendations was not provided. Therefore, the request for Diclofenac Sodium 1.5% Cream 60 GRM was not medically necessary.

**90 CYCLOBENZAPRINE-FLEXERIL 7.5 MG: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines FLEXERIL (CYCLOBENZAPRINE).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

**Decision rationale:** According to page 41 of the California MTUS Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine is recommended as an option, using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended. According to the records reviewed, this patient has been on Cyclobenzaprine since at least 7/1/13. There was no documentation of an acute exacerbation of the patient's pain. Guidelines do not support the long-term use of Cyclobenzaprine. Therefore, the request for 90 Cyclobenzaprine-Flexeril 7.5 mg was not medically necessary.

**90 NAPROXEN SODIUM-ANAPROX 550 MG: 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 9792.24.2 Page(s): 67. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, NSAIDs.

**Decision rationale:** California MTUS states that NSAIDs are effective, although they can cause gastrointestinal irritation or ulceration or, less commonly, renal or allergic problems. Studies have shown that when NSAIDs are used for more than a few weeks, they can retard or impair bone, muscle, and connective tissue healing and perhaps cause hypertension. In addition, ODG states that there is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain. In a progress note dated 1/17/14, it is documented that Anaprox is being discontinued due to gastritis. It is unclear why the physician is requesting this medication when there is documentation that the patient is to discontinue it. Therefore, the request for 90 Naproxen Sodium-Anaprox 550 mg was not medically necessary.

**90 TRAMADOL/APAP 37.5/325 MG:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-81.

**Decision rationale:** California MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In the reports reviewed, there is no documentation of significant pain reduction or improved activities of daily living. Furthermore, there is no documentation of lack of aberrant behavior or adverse side effects, an opioid pain contract, urine drug screen, or CURES monitoring. Furthermore, the records document an increase in work restrictions and indicate that the patient has ceased working since beginning opioid therapy. Therefore, the request for 90 Tramadol/APAP 37.5/325 mg was not medically necessary.