

<b>Case Number:</b>	CM14-0084011		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	02/27/2013
<b>Decision Date:</b>	09/23/2014	<b>UR Denial Date:</b>	05/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2014

### 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 Physical Medicine and Rehabilitation and Pain Medicine, and is licensed to practice in Texas and Ohio. 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 injured worker is a 35-year-old male who reported an injury on 02/27/2013. The mechanism of injury was not provided for clinical review. The diagnoses included lumbago, and sciatica. Previous treatments included medial branch blocks, medication, TENS unit, surgery, and physical therapy. Diagnostic testing included an MRI. Within the clinical note dated 05/19/2014, it was reported the injured worker complained of low back and bilateral lower extremity pain. He rated his pain 7/10 in severity. Upon the physical examination, the provider noted the injured worker had lumbar facet loading being positive on both sides. The provider requested Omeprazole DR, Voltaren XR, Norco, Nortriptyline HCL, Cyclobenzaprine, and a monthly followup. However, a rationale was not provided for clinical review. The Request for Authorization was provided and submitted on 05/20/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Omeprazole Dr 20mg cap #60 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines GI symptoms & cardiovascular risk Page(s): 68-69.

**Decision rationale:** The request for Omeprazole Dr 20 mg cap #60 with 2 refills is not medically necessary. The California MTUS Guidelines note proton pump inhibitors such as Omeprazole are recommended for injured workers at risk for gastrointestinal events and/or cardiovascular disease. The risk factors for gastrointestinal events include: over the age of 65, history of peptic ulcer, gastrointestinal bleeding or perforation, use of corticosteroids, and/or anticoagulants. In the absence of risk factors for gastrointestinal bleeding events, proton pump inhibitors are not indicated when taking NSAIDs. The treatment of dyspepsia from NSAID usage includes stopping the NSAID, switching to a different NSAID, or adding an H2 receptor antagonist or proton pump inhibitor. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. There is a lack of documentation indicating the injured worker had a history of peptic ulcer, gastrointestinal bleed, or perforation. Additionally, there is a lack of documentation indicating the injured worker had a diagnosis of dyspepsia secondary to NSAID therapy. The request submitted failed to provide the frequency of the medication. Therefore, the request for Omeprazole Dr 20 mg cap #60 with 2 refills is not medically necessary.

**Voltaren XR 100mg #30 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

**Decision rationale:** The request for Voltaren XR 100 mg #30 with 2 refills is not medically necessary. The California MTUS Guidelines note topical NSAIDs are recommended for the use of osteoarthritis and tendonitis, in particular that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short-term use of 4 to 12 weeks. Voltaren gel is indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment. It has not been evaluated for treatment of the spine, hip, or shoulder. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the injured worker has been utilizing the medication for an extended period of time since at least 04/2014, which exceeds the guideline recommendations of short-term use. Therefore, the request for Voltaren XR 100 mg #30 with 2 refills is not medically necessary.

**Norco 5/325mg #60 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78.

**Decision rationale:** The request for Norco 5/325 mg #60 with 2 refills is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of

pain relief, functional status, appropriate medication use, and side effects. The Guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The provider did not document an adequate and complete pain assessment within the documentation. There is a lack of documentation indicating the medication had been providing objective functional benefit and improvement. Additionally, the use of a urine drug screen was not provided in the documentation submitted. Therefore, the request for Norco 5/325 mg #60 with 2 refills is not medically necessary.

**Nortriptyline Hcl 10mg cap #30 with 2 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13.

**Decision rationale:** The request for Nortriptyline Hcl 10 mg cap #30 with 2 refills is not medically necessary. The California MTUS Guidelines recommend antidepressants as a first line option for neuropathic pain. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request for Nortriptyline Hcl 10 mg cap #30 with 2 refills is not medically necessary.

**Cyclobenzaprine 7.6mg TID PRN #90 with 2 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

**Decision rationale:** The request for Cyclobenzaprine 7.6 mg three times a day #90 with 2 refills is not medically necessary. The California MTUS recommend non-sedating muscle relaxants as caution as a second line option in short-term treatment of acute exacerbations in patients with chronic low back pain. The Guidelines note the medication is not recommended to be used for longer than 2 to 3 weeks. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The injured worker has been utilizing the medication since at least 05/2014, which exceeds the guideline recommendations of short-term use of 2 to 3 weeks. Therefore, the request for Cyclobenzaprine 7.6 mg three times a day #90 with 2 refills is not medically necessary.

**Monthly follow up visit x 6: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 303.

**Decision rationale:** The request for monthly follow up visit x 6 is not medically necessary. The California MTUS/ACOEM Guidelines state physician followups can occur when a release to modified, increased, or full duty is needed, or after appreciable healing or recovery can be expected on average. There is a lack of documentation of an adequate assessment of pain to warrant the request submitted. There is a lack of documentation indicating the injured worker was released to modified, increased, or full duty. Additionally, the request submitted failed to provide the type of followup to be determined. Therefore, the request for monthly follow up visit x 6 is not medically necessary.