

<b>Case Number:</b>	CM14-0207377		
<b>Date Assigned:</b>	12/19/2014	<b>Date of Injury:</b>	11/09/2009
<b>Decision Date:</b>	03/11/2015	<b>UR Denial Date:</b>	11/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/11/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 57 year old male was injured 11/9/09 while at work involving a motor vehicle accident resulting in neck, left upper extremity, left shoulder, low back and left lower extremity pain. His past history includes chronic pain syndrome, depression, insomnia, myofascial pain, opiate tolerance, osteoarthritis, cervical fusion and shoulder surgery. His medications include omeprazole, cyclobenzaprine, gabapentin, Remeron, methocarbamol, nabumetone and Butrans. He had been through a detoxification program regarding narcotics. The injured worker reports that the pain is controlled with current medication regime but he still experienced sleep difficulties despite the medication. Physical exam of the bilateral upper extremities, bilateral lower extremities and spine revealed on palpation of the region tenderness concordant with the described pain; deep palpation resulted in distal radiation of the pain; global and regional reduced range of motion; reduced muscle strength in the biceps; unable to toe and heel walk; soft tissue dysfunction and spasm in the lumbar paraspinal and gluteal region; shoulder abduction against resistance causes increased pain in the shoulder; straight leg raise on the affected side produces radicular pain. He was able to perform basic activities of daily living. With the exception of medications no other conservative treatment measures were documented. Lumbar MRI (9/23/14) demonstrated moderate to severe right and moderate left neural foraminal stenosis at L3-4; moderate central spinal canal stenosis with moderate right and moderate to severe left neural foraminal stenosis with impingement on the left L4 nerve root at L4-5; moderate to severe bilateral neural foraminal stenosis impinging on both L5 nerve roots and at the L5-S1 level. At this time surgery was discussed. The injured worker is temporarily disabled and off work. On

11/7/14 Utilization Review non-certified the request for cyclobenzaprine 7.5 mg #90 and Omeprazole 20 mg # 30 based on non-recommendation per guidelines of long term muscle relaxants and there is no documentation of gastrointestinal complaints. Guidelines referenced was MTUS.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Cyclobenzaprine 7.5mg # 90:** 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): 64-64.

**Decision rationale:** With regard to muscle relaxants, the MTUS CPMTG states: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement." Regarding Cyclobenzaprine: "Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants (e.g. amitriptyline). Cyclobenzaprine is more effective than placebo in the management of back pain, although the effect is modest and comes at the price of adverse effects."The documentation submitted for review indicates that the injured worker has been taking this medication since at least 8/2014. As it is not recommended for long-term use, the request is not medically necessary.

**Omeprazole 20mg # 30:** Overturned

**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 Guidelines NSAIDs, GI symptoms & Cardiovascular Risk. Page(s): 68.

**Decision rationale:** In the treatment of dyspepsia secondary to NSAID therapy, the MTUS recommends stopping the NSAID, switching to a different NSAID, or considering the use of an H2-receptor antagonist or a PPI. The MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors in conjunction with NSAIDs in situations in which the patient is at risk for gastrointestinal events including: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). CPMTG guidelines further specify: "Recommendations: Patients with no risk factor and no cardiovascular

disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200mg four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxyn plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007) "I respectfully disagree with the UR physician. Per progress report dated 11/25/14, it was noted that the injured worker had gastric reflux and stomach upset secondary to his use of Nabumetone. The request is medically necessary.