

<b>Case Number:</b>	CM15-0130355		
<b>Date Assigned:</b>	07/16/2015	<b>Date of Injury:</b>	11/30/2014
<b>Decision Date:</b>	08/18/2015	<b>UR Denial Date:</b>	06/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/06/2015

### 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: North Carolina

Certification(s)/Specialty: Family Practice

### 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 55-year-old female, who sustained an industrial injury on 11/30/14. Initial complaints were of left side of body injuries. The injured worker was diagnosed as having pain in joint of pelvic region and thigh; pain in joint of lower leg; lumbago; thoracic and lumbosacral neuritis or radiculitis not otherwise specified, myalgia and myositis not otherwise specified; sprains/strains lumbar region; hip and thigh injury not otherwise specified. Treatment to date has included physical therapy; medications. Currently, the PR-2 notes dated 5/12/15 indicated the injured worker is in the office for an initial consultation. She complains of low back and left hip pain. She rates her pain as 6/10 and characterized as aching, dull, prickling, squeezing and throbbing and it radiates to her buttocks. She describes it as constant moderate to severe in no typical pattern and associated with joint stiffness, numbness and tingling in the left foot that has gradually worsened over the last two months. It is aggravated by bending, prolonged sitting, standing or walking. Relieving factors include applications of cold and rest. She has had 6 sessions of physical therapy, which were ineffective. She has trialed Naproxen for her pain and has not trialed antidepressants. Current medications are listed as Tylenol as needed. Her physical examination notes she has a global antalgic gait and uses no assistive devices. Her lumbar spine reveals a lumbar surgical scar. Range of motion is restricted with flexion limited to 30 degrees limited by pain and extension is limited to 10 degrees limited by pain. Palpation of the paravertebral muscles notes spasms, tenderness and tight muscle band on both sides. Spinous process notes tenderness on L4-L5. She can heel/toe walk and lumbar facet loading is positive on both sides. Her straight leg raise is negative on both sides. Inspection of the left hip notes tenderness over the SI joint, trochanter and there are multiple trigger points over the ilio-tibial band. The Gaenslen's and Faber test were positive and internal rotation of the femur resulted in deep buttock pain. Her neurologic examinations were normal for sensory and motor. The provider recommended a left hip steroid injection, chiropractic therapy; acupuncture and a MRI

of the lumbar spine; x-rays of the left hip and lumbar brace. The provider is requesting authorization of Fenoprofen Calcium 400mg #60; Pantoprazole DR 20mg #60 and Cyclobenzaprine 7.5mg #60.

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

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

#### **Fenoprofen Calcium 400 mg #60: 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 NSAID Page(s): 68-72.

**Decision rationale:** The California chronic pain medical treatment guidelines section on NSAID therapy states: Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) This medication is recommended for the shortest period of time and at the lowest dose possible. The shortest period of time is not defined in the California MTUS. The requested medication is within the maximum dosing guidelines per the California MTUS. Therefore, the request is medically necessary.

#### **Pantoprazole DR 20 mg #60: 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 NSAID Page(s): 68-72.

**Decision rationale:** The California chronic pain medical treatment guidelines section on NSAID therapy and proton pump inhibitors (PPI) states: Recommend with precautions as indicated below. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or a anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastro duodenal lesions. 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 (200g 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. There is no documentation provided that places this patient at intermediate or high risk that would justify the use of a PPI. There is no mention of current gastrointestinal or cardiovascular disease. For these reasons, the criteria set forth above per the California MTUS for the use of this medication has not been met. Therefore, the request is not medically necessary.

**Cyclobenzaprine 7.5 mg #60:** 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 muscle relaxants Page(s): 63-65.

**Decision rationale:** The California chronic pain medical treatment guidelines section on muscle relaxants 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. Also, there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) (Chou, 2004) This medication is not intended for long-term use per the California MTUS. The medication has not been prescribed for the flare-up of chronic low back pain. This is not an approved use for the medication. For these reasons, criteria for the use of this medication have not been met. Therefore, the request is not medically necessary.