

Case Number:	CM15-0137846		
Date Assigned:	07/27/2015	Date of Injury:	11/22/2010
Decision Date:	09/03/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	07/16/2015

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: 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:

The injured worker is a 57 year old male who sustained an industrial injury on 11/22/2010. Mechanism of injury was not found in documents provided for review. Diagnoses include end stage osteoarthropathy of the right knee, status post left total knee arthroplasty in December of 2011, and bilateral shoulder rotator cuff tears with impingement and cervical spondylosis. Treatment to date has included diagnostic studies, medications, status post contralateral left total knee arthroplasty in December of 2011, and physical therapy. A physician progress note dated 05/26/2015 documents the injured worker complains of pain in the right knee that he rates as 8 out of 10. He rates his left knee pain as 7 out of 10. He has compensatory left hip and low back pain component. He complains of instability and inquires about a lumbar brace. He also has pain in his cervical spine, and right and left shoulder. His medications allow maintenance of activities of daily living including hygiene, and exercises. Without the medications, he was not able to adhere to his exercise regime. NSAIDs improved range of motion and diminished pain. Without the proton pump inhibitor, he has gastrointestinal upset, and prior to taking the Cyclobenzaprine, he experienced refractory spasm. Spasm was refractory to activity modifications, stretching, heat, and physical therapy and home exercises. There is diffuse tenderness to the left knee and range of motion is 0-90 degrees. There is tenderness to the right knee and 1+effusion. He has tenderness to the lumbar spine a lumboparaspinal musculature. He has tenderness to his bilateral shoulders and positive impingement signs with limited range of motion. The treatment plan includes continuing with the request of a right total knee replacement, a lumbar spine orthotic, continuation of use of Dilaudid and Methadone and a retro

request for a Transcutaneous Electrical Nerve Stimulation unit. Treatment requested is for Cyclobenzaprine 7.5mg #90, Naproxen 550mg #90, and Pantoprazole 20mg #90.

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): 63-64.

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." Per p41 of the MTUS guidelines, the effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment is recommended for the treatment of acute spasm limited to a maximum of 2-3 weeks. UDS that evaluate for cyclobenzaprine can provide additional data on whether the injured worker is compliant, however in this case there is no UDS testing for cyclobenzaprine. The documentation submitted for review indicates that the injured worker has been using this medication since 5/2015. There is no documentation of the patients' specific functional level or percent improvement with treatment with cyclobenzaprine. As it is recommended only for short-term use, the request is not medically necessary.

Naproxen 550mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

Decision rationale: With regard to the use of NSAIDs for chronic low back pain, the MTUS CPMTG states "Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle

relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another." "Low back pain (chronic): Both acetaminophen and NSAIDs have been recommended as first line therapy for low back pain. There is insufficient evidence to recommend one medication over the other. Selection should be made on a case-by-case basis based on weighing efficacy vs. side effect profile." The documentation submitted for review indicates that treating physician has prescribed 550mg TID, which is in excess of the guidelines: 275-550 mg PO twice daily. The maximum dose on day one should not exceed 1375 mg and 1100 mg on subsequent days. As the request does not abide by the MTUS guidelines, the request is not medically necessary. It should be noted that the UR physician has certified a modification of the request for #60.

Pantoprazole 20mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment 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 (200 g 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 naproxen plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)" Per note dated 5/26/15, it is stated that the injured worker has failed first-line proton pump inhibitors with continued gastrointestinal upset. However, it is not specified what specific PPI the injured worker has failed. Absent documentation that the injured worker has failed omeprazole, lansoprazole, and Nexium, the medical necessity of a second-line medication cannot be affirmed. The request is not medically necessary.