MAXIMUS Federal Services

Case Number:	CM15-0165451		
Date Assigned:	09/03/2015	Date of Injury:	10/14/2008
Decision Date:	10/14/2015	UR Denial Date:	08/17/2015
Priority:	Standard	Application Received:	08/24/2015

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
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 58-year-old female, with a reported date of injury of 10-14-2008. The mechanism of injury was not indicated in the medical records provided for review. The injured worker's symptoms at the time of the injury were not indicated. The diagnoses include lumbar spine sprain, strain, and status post right knee arthroscopy. Treatments and evaluation to date have included right knee arthroscopy, home exercise program, and oral medications. The diagnostic studies to date have not been included in the medical records. The progress report dated 08-03-2015 is handwritten and somewhat illegible. The report indicates that the injured worker had a flare-up of low back pain and complained of bilateral knee pain. The injured worker also had spasm in the low back that was increased with activities of daily living, lifting, and walking. The pain was rated 4-7 out of 10. The objective findings include moderate tenderness and spasm in the lumbar spine; positive straight leg raise; decreased sensation in the bilateral lower extremities; decreased lumbar range of motion; negative laxity in the right knee; tenderness of the medial and lateral joint line; and a limp in the right lower extremity. The treatment plan included the prescription of medications. The injured worker's pain was rated 3-4 out of 10 with medications, and 6-7 out of 10 without medications. It was noted that there was no aberrant drug-taking behaviors. It was noted that the injured worker was not working. The treating physician requested Omeprazole 220mg #30 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:

Omeprazole 220mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Omeprazole, Proton-pump inhibitors; www.drugs.com.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The current request is for Omeprazole 220mg #30. Treatments to date have included right knee arthroscopy, home exercise program, physical therapy and oral medications. The patient is currently not working. MTUS, NSAIDs, GI symptoms & cardiovascular risk Section, page 69 states, "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 an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low- dose ASA)." "Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." Per report 08/03/15, the patient presents with a flare-up of low back pain with muscle spasms, and continued pain of the bilateral knee. The pain was rated 4-7 out of 10. The objective findings include moderate tenderness and spasm in the lumbar spine; positive straight leg raise; decreased sensation in the bilateral lower extremities; decreased lumbar range of motion; negative laxity in the right knee; tenderness of the medial and lateral joint line; and a limp in the right lower extremity. Treatment plan was for medications including Diclofenac, cyclobenzaprine and omeprazole. This is the only report provided for review. It is unclear if the requested Omeprazole is for a refill or an attempt at initiating the medication. In any case, the patient is concurrently prescribed Diclofenac, but there is no indication of peptic ulcer disease and GI bleeding or perforation. The treater does not document any recent dyspepsia or GI issues. Routine prophylactic use of PPI without documentation of gastric issues is not supported by guidelines without GI risk assessment. Given the lack of rationale for its use, this request IS NOT medically necessary.

Cyclobenzaprine 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Carisoprodol (Soma), Cyclobenzaprine (Flexeril), Muscle relaxants (for pain).

Decision rationale: The current request is for Cyclobenzaprine 7.5mg #60. Treatments to date have included right knee arthroscopy, home exercise program, physical therapy and oral medications. The patient is currently not working. MTUS, Muscle relaxants (for pain) section, Soma, page 63-66 states Recommend non-sedating muscle relaxants with caution as a second-

line option for short-term treatment of acute exacerbation in patients with chronic LBP. The most commonly prescribed antispasmodic agents are Carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy. Carisoprodol (Soma, Soprodal 350, Vanadom, generic available): Neither of these formulations is recommended for longer than a 2 to 3 week period. Abuse has been noted for sedative and relaxant effects. Per report 08/03/15, the patient presents with a flare-up of low back pain with muscle spasms, and continued pain of the bilateral knee. The pain was rated 4-7 out of 10. The objective findings include moderate tenderness and spasm in the lumbar spine; positive straight leg raise; decreased sensation in the bilateral lower extremities; decreased lumbar range of motion; negative laxity in the right knee; tenderness of the medial and lateral joint line; and a limp in the right lower extremity. Treatment plan was for medications including Diclofenac, cyclobenzaprine and omeprazole. This is the only report provided for review. It is unclear if the requested Cyclobenzaprine is for a refill or an attempt at initiating a new medication. In any case, MTUS recommends antispasmodic agents such as Carisoprodol (Soma) and Cyclobenzaprine (Fexmid), only for a short period (no more than 2-3 weeks), and the current request is for #60 which does not indicate short term use. This request IS NOT medically necessary.