

Case Number:	CM15-0187075		
Date Assigned:	10/06/2015	Date of Injury:	02/28/2013
Decision Date:	12/09/2015	UR Denial Date:	09/01/2015
Priority:	Standard	Application Received:	09/23/2015

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: New York, California
 Certification(s)/Specialty: Emergency Medicine

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 64 year old male injured worker suffered an industrial injury on 2-28-2013. The diagnoses included chronic severe low back pain and bilateral leg pain, chronic severe neck pain and bilateral arm pain, multiple level degenerative disc disease with neuroforaminal narrowing, multiple level cervical and lumbar spondylosis and myofascial pain- spasms. On 7-6-2015, the treating provider reported low back pain that radiated into the posterior aspect of the legs into the knees, left greater than right, neck and bilateral shoulder pain down the arms and hands left greater than right and headaches from the back of the head. The injured worker reported increased pain in the lower left side of the back that radiated to the shoulder He reported the Tizanidine was not helping. The average pain was 7 out of 10. On exam, he had residual low back pain with facet disease. The provider noted the injured worker reported crepitus on range of motion with no new neurological deficit. The Utilization Review on 9-1-2015 determined non-certification for Celecoxib 200mg #60 with 1 refill, modification for Cyclobenzaprine 10mg #90 to #60, Omeprazole 20mg #30, Tizanidine 4mg #60 with 1 refill, and Voltaren Gel 1%, #200.

IMR ISSUES, DECISIONS AND RATIONALES

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

Celecoxib 200mg #60 with 1 refill: 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): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, GI symptoms & cardiovascular risk, NSAIDs, specific drug list & adverse effects.

Decision rationale: Per the MTUS for chronic pain, page 60, medications should be trialed one at a time, and there should be functional improvement with each medication. No reports show any specific functional benefit. The IW has been reported to take this medication for a minimum of 6 months. Systemic toxicity is possible with NSAIDs. The FDA and MTUS recommend monitoring of blood tests and blood pressure. There is no evidence that the prescribing physician is adequately monitoring for toxicity as recommended by the FDA and MTUS. Celecoxib has an elevated cardiovascular risk profile. The treating physician has not provided the specific indications for this NSAID over those with a better cardiovascular profile. Additionally, the request includes 1 refill. This does not support ongoing monitoring of symptoms. The request does not include frequency or dosing. Celebrex is not medically necessary based on the lack of sufficient and specific functional and symptomatic benefit, and prescription not in accordance with the MTUS and the FDA warnings.

Cyclobenzaprine 10mg #90: 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): Cyclobenzaprine (Flexeril).

Decision rationale: According to CA MTUS, cyclobenzaprine is recommended as an option for short course of therapy. Effect is noted to be modest and is greatest in the first 4 days of treatment. The IW has been receiving this prescription for a minimum of 6 months according to submitted records. This greatly exceeds the recommended timeframe of treatment. In addition, the request does not include dosing frequency or duration. The IW's response to this medication is not discussed in the documentation. The request is not medically necessary.

Omeprazole 20mg #30: 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): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: According to CA MTUS, gastrointestinal protectant agents are recommended for patients that are at increased risk for gastrointestinal events. These risks include age >65, history of gastrointestinal bleeding or peptic ulcers, concomitant use of NSAIDs and corticosteroids or aspirin, or high dose NSAID use. The chart does not document any of these risk factors. Past medical history does not include any gastrointestinal disorders, there is no history of poor tolerance to NSAIDs documented and there are not abdominal examinations noted in the chart. Omeprazole is not medically necessary based on the MTUS.

Tizanidine 4mg #60 with 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: CA MTUS guideline states muscle relaxers should be used "as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP." Guidelines further state "Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time." Documentation supports ongoing prescribing of Tizanidine. The IW reports little symptom improvement with the use of Tizanidine. As noted, the guidelines recommend against use for chronic pain. Documentation does not support a new or acute exacerbation of injury. The request is not medically necessary.

Voltaren Gel 1%, #200: 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): Topical Analgesics.

Decision rationale: Voltaren is a non-steroidal anti-inflammatory agent. CA MTUS guidelines state that topical NSAIDs have been shown to have efficacy in the first 2 weeks of osteoarthritis, but afterwards efficacy diminishes. Voltaren Gel is "indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee and wrist.) It has not been evaluated for treatment of spine, hip, or shoulder." The IW has ongoing back and neck pain. The request does not include dosing, frequency, or the intended location of application. Without support of the documentation or adherence to the guidelines, the request for Voltaren is not medically necessary.