

<b>Case Number:</b>	CM15-0204932		
<b>Date Assigned:</b>	10/21/2015	<b>Date of Injury:</b>	08/24/2011
<b>Decision Date:</b>	12/09/2015	<b>UR Denial Date:</b>	10/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/19/2015

### 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 61 year old male who sustained an industrial injury on 08-24-2011. According to a progress report dated 10-06-2015 MRI of the lumbar spine showed disc herniation at L4-L5 and stenosis at L4-L5 and L5-S1 with facet arthropathy at L3-L4. Nerve studies of the lower extremities showed polyneuropathy. Twelve therapy sessions for the low back had "materialized". The injured worker had access to a back brace which was still "doing well" with him. He was trying to lose over 70-90 pounds. He used and cane. He had access to a DonJoy brace for both knees. He had access to a large TENS unit with conductive garment and a hot and cold wrap. He was still on Coumadin and he was about to have possible ablation of atrial fibrillation. He still had episodes of dizziness which he attributed to Coumadin. He had an irregular heart rhythm and was using medication. He also had dilation and edema along his ankles. He had received two series of Hyalgan for each knee that had "really helped" to improve his activity level. Chores around the house were minimized. Sitting tolerance was 20-25 minutes. Standing and walking was no more than 35 minutes. Lifting was no more than 15 pounds. Objective findings included elevated blood pressure. The provider noted that the injured worker would be going to his family doctor to get his blood pressure checked since he was also having some chest pain. Knee extension was 180 degrees. Flexion was 110 degrees on the right and 115 on the left. Shoulder elevation and abduction was 155 degrees with grade 5 minus strength to resisted abduction, adduction and external rotation. Diagnoses included internal derangement of the knee on the right, internal derangement of the knee on the left, impingement syndrome of the shoulder on the right status post two operations and discogenic lumbar condition with radicular

component down the lower extremities. The provider also noted an element of atrial fibrillation and the need for Coumadin, sleep apnea which had gotten worse, gastrointestinal irritations and stress disorder. Due to chronic pain, the injured worker had developed depression and erectile dysfunction. Standing x-rays done through another provider revealed abutment of the femur to the tibia medially, suggesting grade IV arthritis medially. The treatment plan included Norflex, ER, Protonix, Tramadol ER and Neurontin. The provider noted that the injured worker could do sedentary type work. An authorization request dated 10-06-2015 was submitted for review. The requested services included Norflex ER 100 mg #120, Protonix 20 mg #120, Tramadol ER 150 mg #60 and Neurontin 600 mg #180. The provider noted in previous progress reports that the injured worker was unable to take anti-inflammatories due to his Coumadin situation as well as a bleed found during a colonoscopy. He also was noted to have gastroesophageal reflux disease issues and needed Protonix. On 10-16-2015, Utilization Review non-certified the request for Norflex 100 mg #120 and Protonix 20 mg #120 and authorized the request for Tramadol and Neurontin.

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

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

**Norflex 100 mg #120:** Upheld

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

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

**Decision rationale:** With regard to muscle relaxants, the MTUS 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." Regarding Orphenadrine: This drug is similar to diphenhydramine, but has greater anticholinergic effects. The mode of action is not clearly understood. Effects are thought to be secondary to analgesic and anticholinergic properties. This drug was approved by the FDA in 1959. Side Effects: Anticholinergic effects (drowsiness, urinary retention, dry mouth). Side effects may limit use in the elderly. This medication has been reported in case studies to be abused for euphoria and to have mood elevating effects. (Shariatmadari, 1975) As the guidelines do not recommend sedating muscle relaxants, the request is not medically necessary; Furthermore, Norflex has been in use since at least 4/2015 and it is only recommended for short-term use.

**Protonix 20 mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Proton Pump Inhibitors.

**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 cardio protection) 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)" Per ODG TWC, "many prescribers believe that this class of drugs is innocuous, but much information is available to demonstrate otherwise. A trial of omeprazole or lansoprazole is recommended before Nexium therapy. The other PPIs, Protonix, Dexilant, and Aciphex, should also be second-line." As there is no documentation of peptic ulcer, GI bleeding or perforation, or cardiovascular disease in the records available for my review, the injured worker's risk for gastrointestinal events is low, as such, medical necessity cannot be affirmed. Furthermore, as noted per the guidelines, Protonix is a second-line medication. Per the medical records, the injured worker was using Prilosec. There was no documentation that this was ineffective. The request is not medically necessary.