

<b>Case Number:</b>	CM15-0025222		
<b>Date Assigned:</b>	02/17/2015	<b>Date of Injury:</b>	01/27/2014
<b>Decision Date:</b>	04/23/2015	<b>UR Denial Date:</b>	01/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2015

### 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 was a 39 year old female, who sustained an industrial injury, January 27, 2014. The injured was caused by standing with repetitive box opening was flaring-up the injured workers symptoms of pain. According to progress note of October 29, 2014, the injured workers chief complaint was low back pain. The injured worker had a second epidural injection at the level of L-S1 transforaminal. The injured worker reported improvement, but not enough to go back to work. The lumbar flexion of 75 degrees of 90 degrees, extension was 10 degrees of 20 and left and right rotation was 15 degrees of 30, left and right lateral bend was 15 degrees of 30. There was tenderness noted at the paralumbar extensors, facet joints, S1 joint, gluteus medius and greater trochanters. The injured worker was positive for straight leg raises. The injured worker was diagnosed with lumbar strain/sprain of the lower back, left lumbosacral radiculopathy and lumbar discogenic syndrome. The injured worker previously received the following treatments physiatric services, lumbar epidural steroid injections, Cyclobenzaprine, Naproxen and Biofreeze Muscle Gel. The primary treating physician requested authorization for retrospective prescriptions of Omeprazole 20mg and Cyclobenzaprine from December 18, 2014 and a TENS (transcutaneous electrical nerve stimulator) unit and TENS unit patches. On January 16, 2015, the Utilization Review denied authorization for retrospective prescriptions of Omeprazole 20mg and Cyclobenzaprine from December 18, 2014 and a TENS (transcutaneous electrical nerve stimulator) unit and TENS unit patches. The denial was based on the MTUS/ACOEM and ODG guidelines.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Retrospective request for Omeprazole 20 mg, DOS 12/18/14: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68.

**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 naproxyn plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)"The documentation submitted for review indicates that the injured worker has had gastric upset while on NSAID therapy. As such, the request is medically necessary.

### **Retrospective request for Cyclobenzaprine 7.5 mg, DOS 12/18/14: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 41.

**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." The patient is not being treated for an acute exacerbation of chronic back pain, so the requested treatment is not medically necessary.