

<b>Case Number:</b>	CM15-0222879		
<b>Date Assigned:</b>	11/18/2015	<b>Date of Injury:</b>	11/16/2007
<b>Decision Date:</b>	12/30/2015	<b>UR Denial Date:</b>	10/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2015

### 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, Oregon, Washington  
Certification(s)/Specialty: Orthopedic Surgery

### 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 female, who sustained an industrial injury on November 16, 2007. She reported the onset of low back and left lower extremity pain. The injured worker was currently diagnosed as having lumbago, internal derangement of knee involving medial meniscus, lumbar facet arthropathy, lumbar foraminal stenosis, primary localized osteoarthritis lower leg, thoracic spondylosis without myelopathy and lumbar paraspinal muscle spasm. On October 13, 2015, the injured worker complained of low back and left lower extremity pain. Her pain was described as constant, dull and sharp. The pain was rated as a 10 on a 0-10 pain scale. The pain was noted to be made worse by standing a long time and getting up from a seated position. Notes stated that she tried and failed hydrocodone, Norco, Vicodin, oxycodone, IV morphine and Dilaudid. She stated that Gabapentin was not effective and Roxicodone caused dizziness and memory loss. She noted some relief with the use of Robaxin. On the day of exam, her current medications included ibuprofen, methocarbamol, Prilosec, Cymbalta, diclofenac sodium and Nucynta ER. The treatment plan included discontinuing Roxicodone, discontinuing Gabapentin, discontinuing Meloxicam, prescription for Nucynta, prescription for Cymbalta and prescription for Diclofenac. On October 26, 2015, utilization review denied a retrospective request for Methocarbamol 750mg and Diclofenac Sodium DR 75mg (date of service 10-13-15). A retrospective request for Prilosec 40mg #60, Cymbalta 30mg #60, Nucynta ER 50mg #90 and Ibuprofen 800mg #60 (date of service 10-13-15) was authorized.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Dos: 10/13/15 Methocarbamol 750mg: 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): Muscle relaxants (for pain).

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines, pages 64-65, reports that muscle relaxants such as Robaxin are recommended to decrease muscle spasm in condition such as low back pain although it appears that these medications are often used for the treatment of musculoskeletal conditions whether spasm is present or not. The mechanism of action for most of these agents is not known. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen. According to a recent review in American Family Physician, skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and 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. In this case the patient has no evidence in the records of significant spasms objectively, the determination is for non-certification for Robaxin as it is not medically necessary.

**Retrospective Dos: 10/13/15, Diclofenac Sodium DR 75mg: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain section, diclofenac.

**Decision rationale:** The CA MTUS is non-specific on the recommendations for prescribing of diclofenac. According to the ODG-TWC, pain section, diclofenac is not recommended as first line due to increased risk profile. A large systematic review of available evidence on NSAIDs confirms that diclofenac, a widely used NSAID, poses an equivalent risk of cardiovascular events to patients as did rofecoxib (Vioxx), which was taken off the market. According to the authors, this is a significant issue and doctors should avoid diclofenac because it increases the risk by about 40%. The ODG continues to state that "If using diclofenac then consider discontinuing as it should only be used for the shortest duration possible in the lowest effective dose due to reported serious adverse events. Post marketing surveillance has revealed that treatment with all oral and topical diclofenac products may increase liver dysfunction, and use has resulted in liver failure and death." Due to this risk and "the lack of data to support superiority of diclofenac over other NSAIDs and the possible increased hepatic and cardiovascular risk associated with its use, alternative analgesics and/or non-pharmacological therapy should be considered." In this case review of the medical records from 10/13/15 do not show a failure of a 1st line NSAID. Also ODG guidelines recommend against continued use of diclofenac. Thus the prescription is not medically necessary and the recommendation is for non-certification.