

<b>Case Number:</b>	CM15-0086649		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	04/07/2014
<b>Decision Date:</b>	09/16/2015	<b>UR Denial Date:</b>	04/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/05/2015

### 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: 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 injured worker is a 59 year old male who sustained an industrial injury on 4/7/14. The injured worker was diagnosed as having status post motor vehicle accident, cervical sprain/strain, lumbar sprain/strain and right rotator cuff sprain/strain. Currently, the injured worker was with complaints of discomfort in the cervical spine, lumbar spine and right shoulder. Previous treatments included physical therapy and medication management. The injured workers pain level was noted as 4/10 in the cervical spine without medication and 3/10 with medication; 7/10 in the lumbar spine without medication and 4/10 with medication; 7/10 in the right shoulder without medication and 4/10 with medication. The plan of care was for medication prescriptions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Anaprox/Naprosyn 550mg #60, DOS: 2/3/15 & 3/3/15: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-68 of 127.

**Decision rationale:** The request is for the use of NSAIDs to aid in pain relief. NSAIDs are usually used to aid in pain and inflammation reduction. The MTUS guidelines states that for osteoarthritis NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen especially for patients with moderate to severe pain. There is no evidence to support one drug in this class over another based on efficacy. In particular, there appears to be no difference between NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects, with COX-2 NSAIDs having fewer GI side effects at the risk of increased cardiovascular side effects. The FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain and function. (Chen, 2008) (Laine, 2008) For back pain, NSAIDs are recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute LBP. (van Tulder, 2006) (Hancock, 2007) For patients with acute low back pain with sciatica a recent Cochrane review (including three heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs vs. placebo. In patients with axial low back pain this same review found that NSAIDs were not more effective than acetaminophen for acute low-back pain, and that acetaminophen had fewer side effects. (Roelofs-Cochrane, 2008) The addition of NSAIDs or spinal manipulative therapy does not appear to increase recovery in patients with acute low back pain over that received with acetaminophen treatment and advice from their physician. (Hancock, 2007) In this case, there is inadequate documentation of functional improvement to justify continued use, as the guidelines recommend the lowest dose for the shortest period of time. The significant side effect profile of medications in this class put the patient at risk when used chronically. As such, the request is not certified or medically necessary.

**Retrospective Prilosec/Omeprazole 20mg #60, DOS: 2/3/15 & 3/3/15: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68 of 127.

**Decision rationale:** The request is for the use of a medication in the class of a proton pump inhibitor. This is usually given as an acid reducing medication for patients with esophageal reflux, gastritis, or peptic ulcer disease. It can also be used as a preventative measure in patients taking non-steroidal anti-inflammatories for chronic pain. Unfortunately, they do have certain side effects including gastrointestinal disease. The MTUS guidelines states that patients who are classified as intermediate or high risk, should be treated prophylactically. Criteria for risk are as follows: "(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)." Due to the fact the patient does not meet to above stated criteria, the request for use is not certified or medically necessary.

**Retrospective Tramadol/Acetaminophen 37.5/325mg #60, DOS: 3/5/15: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80-83 of 127.

**Decision rationale:** Tramadol is a pain medication in the category of a centrally acting analgesic. They exhibit opioid activity and a mechanism of action that inhibits the reuptake of serotonin and norepinephrine. Centrally acting drugs are reported to be effective in managing neuropathic type pain although it is not recommended as first line therapy. The side effect profile is similar to opioids. For chronic back pain, it appears to be efficacious for short-term pain relief, but long term (>16 weeks) results are limited. It also did not appear to improve function. The use of tramadol for osteoarthritis is indicated for short-term use only (<3 months) with poor long-term benefit. In this case, the patient does not meet the qualifying criteria or indications. As such, the request is not certified or medically necessary.

**Retrospective Cyclobenzaprine 10mg #60, DOS: 2/3/15 & 3/5/15: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants for pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63 of 127.

**Decision rationale:** The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate qualifying evidence for use of a muscle relaxant, the request is not certified or medically necessary.

**Cyclobenzaprine 2%/Gabapentin 15%/ Amitriptyline 10%: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

**Decision rationale:** The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the use of the topical muscle relaxant is not indicated for use for the patient's condition. The MTUS states the following: "There is no evidence for use of any other muscle relaxant as a topical product." As such, the request is not certified or medically necessary.

**Capsaicin 0.025%/Flurbiprofen 15%/Gabapentin 10%/Menthol 2%/Camphor 2%:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

**Decision rationale:** The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the use of gabapentin is stated to be not indicated for use for the patient's condition. The guidelines state the following: "Gabapentin: Not recommended. There is no peer-reviewed literature to support use." As such, the request is not certified or medically necessary.

**NPCI Gabapentin 10%/Amitriptyline 10%/Bupivacaine 5% in cream base:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

**Decision rationale:** The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the use of gabapentin is stated to be not indicated for use for the patient's condition. The guidelines state the following: "Gabapentin: Not recommended. There is no peer-reviewed literature to support use." As such, the request is not certified.

**MPHCCI Flurbiprofen 20%/Baclofen 5%/Dexamethasone 2%/Menthol 2%/Camphor 2%/Capsaicin 0.025% in cream base:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

**Decision rationale:** The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the use of the topical muscle relaxant is not indicated for use for the patient's condition. The MTUS states the following: "There is no evidence for use of any other muscle relaxant as a topical product." As such, the request is not certified or medically necessary.