

<b>Case Number:</b>	CM15-0089226		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	03/17/2014
<b>Decision Date:</b>	06/15/2015	<b>UR Denial Date:</b>	04/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2015

### 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: Physical Medicine & Rehabilitation

### 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 March 17, 2014. The injured worker was diagnosed as having lumbar degenerative disc disease (DDD), spondylolisthesis and stenosis. Treatment and diagnostic studies to date have included magnetic resonance imaging (MRI), x-ray and medication. A progress note dated March 30, 2015 provides the injured worker complains of low back pain with numbness in the legs. Magnetic resonance imaging (MRI) was reviewed. Physical exam notes lumbar tenderness with decreased range of motion (ROM) and spasm. The plan includes epidural steroid injection, Voltaren, Flexeril and Protonix.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Voltaren 100 mg #60 1 refill (3/30/15): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines NSAIDs, GI symptoms, Cardiovascular risks.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), Page 22.

**Decision rationale:** Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. Monitoring of NSAID's functional benefit is advised as per Guidelines, long-term use of NSAIDS beyond a few weeks may actually retard muscle and connective tissue healing and increase the risk of hip fractures. Available reports submitted have not adequately addressed the indication to continue a NSAID for a chronic injury nor have they demonstrated any functional efficacy derived from treatment already rendered. The Retrospective Voltaren 100 mg #60 1 refill (3/30/15) is not medically necessary and appropriate.

**Retrospective Flexeril 7.5 mg #90 (3/30/15): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants, pg 128.

**Decision rationale:** The patient has been prescribed a muscle relaxant since April 2014. Guidelines do not recommend long-term use of this muscle relaxant for this chronic injury. Additionally, the efficacy in clinical trials has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. Submitted reports have not adequately demonstrated the indication or medical need for this treatment and there is no report of significant clinical findings, acute flare-up or new injury to support for its long-term use. There is no report of functional improvement resulting from its previous treatment to support further use as the patient remains unchanged. The Retrospective Flexeril 7.5 mg #90 (3/30/15) is not medically necessary and appropriate.

**Retrospective Protonix 20 mg #60 (3/30/15): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain chapter (chronic), PPI.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular risk, Pages 68-69.

**Decision rationale:** Protonix medication is for treatment of the problems associated with erosive esophagitis from GERD, or in patients with hypersecretion diseases. Per MTUS Chronic Pain Treatment Guidelines, the patient does not meet criteria for Protonix namely reserved for patients with history of prior GI bleeding, the elderly (over 65 years), diabetics, and chronic cigarette smokers. Submitted reports have not described or provided any GI diagnosis that meets the criteria to indicate medical treatment. Review of the records show no documentation of any history, symptoms, or GI diagnosis to warrant this medication. The Retrospective Protonix 20 mg #60 (3/30/15) is not medically necessary and appropriate.

