

<b>Case Number:</b>	CM15-0236637		
<b>Date Assigned:</b>	12/14/2015	<b>Date of Injury:</b>	04/30/1978
<b>Decision Date:</b>	01/20/2016	<b>UR Denial Date:</b>	11/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/03/2015

### 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 74 year old female with an industrial injury dated 04-30-1978. A review of the medical records indicates that the injured worker is undergoing treatment for chronic back pain. According to the most recent progress note dated 06-25-2015, the injured worker presented for follow up for chronic back pain. Pain level was 4 out of 10, average pain level 5 out of 10, and worst pain level 8 out of 10 on a visual analog scale (VAS). Medications include Lovastatin, Promethazine, Omeprazole, Diclofenac sodium (started on 06-25-2015), Hydrochlorothiazide, Amlodipine besylate, levothyroxine, Gabapentin, Cymbalta, Cyclobenzaprine (since at least 2014), and Norco. Objective findings (06-25-2015) revealed no acute distress and obvious loss of lumbar lordosis with tender palpable plates along the spine under the skin. Treatment has included diagnostic studies, back surgery x7, prescribed medications, and periodic follow up visits. The utilization review dated 11-16-2015, non-certified the request for Diclofenac DR 75mg, #180 and Cyclobenzaprine 10mg, #270.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Diclofenac DR 75mg, #180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-inflammatory medications. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (chronic) chapter under Diclofenac.

**Decision rationale:** The 74 year old patient complains of back pain, rated at 4-8/10, as per progress report dated 06/25/15. The request is for DICLOFENAC DR 75mg, #180. There is no RFA for this case, and the patient's date of injury is 04/30/78. The patient is status post seven back surgeries, status post total knee replacement, and status post foot surgery, as per progress report dated 06/25/15. Diagnoses included diarrhea, hyperlipidemia, hyperthyroidism, chronic back pain, and hypertension. Medications for the back pain include Norco, Cymbalta, Gabapentin, Diclofenac, and Promethazine. The patient is retired, as per the same progress report. MTUS Chronic Pain Medical Treatment Guidelines 2009 page 67 and 68 and Anti-inflammatory medications section, Chronic Pain Medical Treatment Guidelines 2009, recommend NSAIDs (non-steroidal anti-inflammatory drugs) as an option for short-term symptomatic relief. ODG guidelines, Pain (chronic) chapter under Diclofenac state: 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%. It goes on to state that there is substantial increase in stroke. In this case, Diclofenac is first noted in progress report dated 10/01/14. It is not clear when the medication was initiated. The reports do not document the efficacy of the medication and its impact on the patient's pain and function. Additionally, the reports available for review do not indicate the use and failure of other NSAIDs, and ODG does not support the use of Diclofenac unless other NSAIDs have failed as it increases the risk of stroke by about 40%. Hence, the request IS NOT medically necessary.

**Cyclobenzaprine 10mg, #270:** Upheld

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

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

**Decision rationale:** The 74 year old patient complains of back pain, rated at 4-8/10, as per progress report dated 06/25/15. The request is for CYCLOBENZAPRINE 10mg, #270. There is no RFA for this case, and the patient's date of injury is 04/30/78. The patient is status post seven back surgeries, status post total knee replacement, and status post foot surgery, as per progress report dated 06/25/15. Diagnoses included diarrhea, hyperlipidemia, hyperthyroidism, chronic back pain, and hypertension. Medications for the back pain include Norco, Cymbalta, Gabapentin, Diclofenac, and Promethazine. The patient is retired, as per the same progress

report. MTUS Chronic Pain Medical Treatment Guidelines 2009, pg 63-66 and Muscle Relaxants section, state: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP. 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. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy. MTUS, Chronic Pain Medication Guidelines 2009, Muscle Relaxants, page 63-66: "Carisoprodol (Soma, Soprodal 350, Vanadom, generic available): Neither of these formulations is recommended for longer than a 2 to 3 week period." Abuse has been noted for sedative and relaxant effects. In this case, Cyclobenzaprine is first noted in progress report dated 10/01/14. In the report, the treater states that the patient did not get relief from muscle spasms until she was placed on Flexeril. The reports do not discuss the efficacy of the medication on the patient's function. Additionally, MTUS does not support long-term use of muscle relaxants beyond a 2 to 3 week period. Hence, the request for # 270 IS NOT medically necessary.