

<b>Case Number:</b>	CM14-0163719		
<b>Date Assigned:</b>	10/08/2014	<b>Date of Injury:</b>	11/07/2011
<b>Decision Date:</b>	11/04/2014	<b>UR Denial Date:</b>	09/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2014

### 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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 57-year-old female with an 11/7/11 date of injury. At the time (7/23/14) of the request for authorization for 1 prescription for 90 omeprazole/flurbiprofen 100mg with 3 refills, 1 prescription for 90 Lunesta 1 mg with 3 refills, 1 prescription for 90 methocarbamol 750mg with 3 refills, and 1 prescription for flurbiprofen/lidocaine 20%/5% cream 180gm with 3 refills, there is documentation of subjective (lower back constant muscle tightness and pain at a 6/10, back pain radiates into the top of the buttocks, neck pain with constant tightness and pain and occasional spasms, pain radiates into the shoulders and down the back, tingling radiates into the middle two fingers, stiffness is causing limited range of motion in the neck) and objective (decreased cervical spine range of motion) findings, current diagnoses (musculoligamentous sprain lumbar spine with right lower extremity radiculitis, musculoligamentous sprain of the cervical spine, herniated disc C4-5 and C5-6, herniated disc L5-S1, and facet hypertrophy L4-5 and L5-S1), and treatment to date (medication including NSAIDs and muscle relaxants for at least a year). Regarding 1 prescription for 90 omeprazole/flurbiprofen 100mg with 3 refills, there is no documentation of high dose/multiple NSAID; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with flurbiprofen use to date. Regarding 1 prescription for 90 Lunesta 1 mg with 3 refills, there is no documentation of insomnia. Regarding 1 prescription for 90 methocarbamol 750mg with 3 refills, there is no documentation of acute exacerbation of chronic low back pain and used as a second line option for short-term treatment; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with methocarbamol use to date.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **1 prescription for 90 omeprazole/flurbiprofen 100mg with 3 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk, Proton Pump Inhibitors.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs); NSAIDs, GI symptoms & cardiovascular risk Page(s). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Proton pump inhibitors (PPIs) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe osteoarthritis pain, acute low back pain, chronic low back pain, or exacerbations of chronic pain, as criteria necessary to support the medical necessity of NSAIDs. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies that risk for gastrointestinal event includes age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; and/or high dose/multiple NSAID. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of risk for gastrointestinal events, preventing gastric ulcers induced by NSAIDs, as criteria necessary to support the medical necessity of proton pump inhibitors. Within the medical information available for review, there is documentation of diagnoses of musculoligamentous sprain lumbar spine with right lower extremity radiculitis, musculoligamentous sprain of the cervical spine, herniated disc C4-5 and C5-6, herniated disc L5-S1, and facet hypertrophy L4-5 and L5-S1. In addition, there is documentation of chronic low back pain. However, there is no documentation of high dose/multiple NSAID. In addition, given documentation of treatment with NSAIDs for at least a year, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with flurbiprofen use to date. Therefore, based on guidelines and a review of the evidence, the request for 1 prescription for 90 omeprazole/flurbiprofen 100mg with 3 refills is not medically necessary.

### **1 prescription for 90 lunesta 1 mg with 3 refills: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lunesta

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomina treatment

**Decision rationale:** ODG states non-benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists) are first-line medications for insomnia which includes eszopicolone (Lunesta). In addition, ODG identifies that Lunesta is the only benzodiazepine-receptor agonist FDA approved for use longer than 35 days. Within the medical information available for review, there is documentation of diagnoses of musculoligamentous sprain lumbar spine with right lower extremity radiculitis, musculoligamentous sprain of the cervical spine, herniated disc C4-5 and C5-6, herniated disc L5-S1, and facet hypertrophy L4-5 and L5-S1. However, there is no documentation of insomnia. Therefore, based on guidelines and a review of the evidence, the request for 1 prescription for 90 Lunesta 1 mg with 3 refills is not medically necessary.

**1 prescription for 90 methocarbamol 750mg with 3 refills: 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 MUSCLE RELAXANTS (FOR PAIN) Page(s): 63-64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of acute exacerbation of chronic low back pain and used as a second line option for short-term treatment, as criteria necessary to support the medical necessity of muscle relaxant. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended for short-term (less than two weeks) treatment. Within the medical information available for review, there is documentation of diagnoses of musculoligamentous sprain lumbar spine with right lower extremity radiculitis, musculoligamentous sprain of the cervical spine, herniated disc C4-5 and C5-6, herniated disc L5-S1, and facet hypertrophy L4-5 and L5-S1. However, there is no documentation of acute exacerbation of chronic low back pain and used as a second line option for short-term treatment. In addition, given documentation of treatment with muscle relaxants for at least a year, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with methocarbamol use to date. Therefore, based on guidelines and a review of the evidence, the request for 1 prescription for 90 methocarbamol 750mg with 3 refills is not medically necessary.

**1 prescription for flurbiprofen/lidocaine 20%/5% cream 180gm with 3 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications; Lidocaine, topical, Lidoderm.

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

**Decision rationale:** Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Within the medical information available for review, there is documentation of diagnoses of musculoligamentous sprain lumbar spine with right lower extremity radiculitis, musculoligamentous sprain of the cervical spine, herniated disc C4-5 and C5-6, herniated disc L5-S1, and facet hypertrophy L4-5 and L5-S1. However, the requested 1 prescription for flurbiprofen/lidocaine 20%/5% cream 180gm with 3 refills contains at least one drug (lidocaine) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request for 1 prescription for flurbiprofen/lidocaine 20%/5% cream 180gm with 3 refills is not medically necessary.