

<b>Case Number:</b>	CM14-0215707		
<b>Date Assigned:</b>	01/05/2015	<b>Date of Injury:</b>	04/21/2014
<b>Decision Date:</b>	02/23/2015	<b>UR Denial Date:</b>	12/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2014

### 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. 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: Ohio, North Carolina, Virginia  
Certification(s)/Specialty: Family Practice

### CLINICAL CASE SUMMARY

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

This 50 year old female sustained a work related injury on 4/21/2014. The mechanism of injury was reported to be injury from jumping over a hole and upon landing, the dirt sank in, causing her to fall on her knees and land onto the left side of her body. The current diagnoses are low back pain, left SI joint dysfunction, muscle spasms, myofascial pain syndrome, and chronic pain syndrome. According to the progress report dated 11/21/2014, the injured workers chief complaints were constant low back pain that radiates to her bilateral knees, 7/10 on a subjective pain scale. The pain was described as pins and needles. The physical examination revealed tenderness to palpation along the paraspinal muscles from the thoracic vertebrae down to the lumbar vertebrae. She was tender to palpation in the left SI joint and the left piriformis muscle. She was unable to tolerate the FABRE maneuver on the left side. Range of motion to lumbar flexion was 60 degrees, lumbar extension 15 degrees, left and right side bending 15 degrees, and left and right rotation 15 degrees. Current medications are Gabapentin and Tylenol. On this date, the treating physician prescribed Diclofenac 100mg #30, which is now under review. The treating physician did not describe any specific reasons for prescribing the Diclofenac. In addition to Diclofenac, the treatment plan included Flexeril, Effexor XR, trigger point injections, orthopedic consultation, urinary drug testing, and physical therapy. The injured worker was previously treated with pain medications, braces/casts, physical therapy, TENS unit, trigger point injections, and exercises. When Diclofenac was prescribed work status was temporarily totally disabled. The record reflects that the injured worker had been treated continuously with the NSAID Naproxen since at least 4-28-2014. On 12/12/2014, Utilization Review had non-certified

a prescription for Diclofenac 100mg #30. The Diclofenac was non-certified based on no documentation of the injured workers response to first-line NSAIDs. The Official Disability Guidelines were cited.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Diclofenac 100mg #30:** Overturned

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain (Chronic)

**Decision rationale:** NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain due to osteoarthritis. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although 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). Diclofenac is not recommended as first line medication for pain 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%. For a patient who has a 5% to 10% risk of having a heart attack, that is a significant increase in absolute risk, particularly if there are other drugs that don't seem to have that risk. For people at very low risk, it may be an option. In this instance, the first line anti-inflammatory Naproxen was in continuous use for at least 7 months prior with unsatisfactory results. The injured worker does not appear to possess significant cardiovascular risk factors. She did try acetaminophen first line for pain prior to NSAIDs. She does have an osteoarthritic condition, lumbar facet disease. Consequently, Diclofenac 100mg #30 is medically necessary.