

<b>Case Number:</b>	CM15-0014616		
<b>Date Assigned:</b>	02/02/2015	<b>Date of Injury:</b>	09/20/1995
<b>Decision Date:</b>	03/27/2015	<b>UR Denial Date:</b>	01/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/26/2015

### 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, Arizona  
 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 52-year-old female who reported an injury on 09/20/1995. Her mechanism of injury was twisting. Her diagnoses included low back pain, lumbar radiculopathy, and post lumbar spine surgery syndrome. Her medications included cyclobenzaprine, Cymbalta, Lidoderm patch, Xarelto, Dyazide, Dexilant, ibuprofen, and Norco. Her surgeries included a discectomy in 03/1996, and a 3 level fusion in 01/2001. Her treatment plan included review of CURES report and collection of a urine drug screen, trial of spinal cord stimulator and request for thoracic MRI.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cyclobenzaprine 100mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63-64.

**Decision rationale:** The request for Cyclobenzaprine 100mg #60 is not medically necessary. The California MTUS guidelines state muscle relaxants are recommended as a second line option for the short term treatment of acute low back pain and their use is recommended for less than 3 weeks. Cyclobenzaprine is associated with a number needed to treat of 3 at 2 weeks for symptom improvement. The greatest effect appears to be in the first 4 days of treatment. There is a lack of documentation regarding the failure of first line treatment for acute low back pain. The guidelines state the use of muscle relaxants is short term and recommended for less than 3 weeks. The request for cyclobenzaprine 100mg #60 is not medically necessary.

**Cymbalta:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta) Page(s): 43-44.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16.

**Decision rationale:** The request for Cymbalta is not medically necessary. The California MTUS guidelines state Duloxetine (Cymbalta) is FDA-approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. Used off-label for neuropathic pain and radiculopathy. Duloxetine is recommended as a first-line option for diabetic neuropathy. (Dworkin, 2007) No high quality evidence is reported to support the use of duloxetine for lumbar radiculopathy. There is a lack of documentation regarding objective improvement using this medication. There is also a lack of documentation regarding symptoms of neuropathic pain or radiculopathy. The request does not include strength, route, frequency, or dose. The request for Cymbalta is not medically necessary.

**Lidoderm patch #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56-57.

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

**Decision rationale:** The request for Lidoderm patch #60 is not medically necessary. The California MTUS guidelines state it is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Not recommended for non-neuropathic pain. There is a lack of documentation peripheral, neuropathic pain. There is also a lack of documentation regarding a failure of a trial of first line therapy. The request does not include strength, placement of the patch, or frequency. The request for Lidoderm patch #60 is not medically necessary.

**Xarelto:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Rivaroxaban (Xarelto®).

**Decision rationale:** The request for Xarelto is not medically necessary. The Official Disability Guidelines state xarelto is recommended as an anticoagulation treatment option for patients with venous thromboembolisms (VTEs) of the leg. A major RCT (RECORD4) showed that oral rivaroxaban 10 mg once daily for 10 to 14 days was significantly superior to subcutaneous enoxaparin 30 mg given every 12 hours for the prevention of venous thromboembolism (VTE) after total knee arthroplasty. Rivaroxaban is one of several new oral anticoagulants, which offer an alternative to warfarin, which is widely used but has many drawbacks, including an unpredictable response and the need for constant monitoring. Rivaroxaban is recommended for the prophylaxis of deep vein thrombosis (DVT) and pulmonary embolism (PE) in patients undergoing hip- and knee-replacement surgery. There is a lack of documentation regarding monitoring of the injured worker's coagulation studies. The request does not include route, dose, or frequency. The request for Xarelto is not medically necessary.

**Dyazide:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRPS, treatment Page(s): 40.

**Decision rationale:** The request for Dyazide is not medically necessary. The California MTUS guidelines state edema control may also be required (elevation, retrograde sympathetic blocks, diuretics and adrenoceptor blockers when sympathetically maintained pain-SMP is present). There is a lack of documentation regarding edema monitoring, or other rationale for use of this medication. The request does not include the route, the dose, or the frequency. The request for Dyazide is not medically necessary.

**Dexilant:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk Page(s): 68-69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-70.

**Decision rationale:** The request for Dexilant is not medically necessary. The California MTUS guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. Clinicians should determine if the patient is at risk for gastrointestinal events which include age > 65 years, a history of peptic ulcer, GI bleeding or

perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant; or using a high dose/multiple NSAIDs. There is a lack of documentation regarding dyspepsia or other gastrointestinal events. There is also a lack of documentation regarding objective functional improvement or relief with this medication. The request does not include route, dose, or frequency. The request for Dexilant is not medically necessary.