

Case Number:	CM15-0016532		
Date Assigned:	02/04/2015	Date of Injury:	03/17/2014
Decision Date:	03/27/2015	UR Denial Date:	01/02/2015
Priority:	Standard	Application Received:	01/28/2015

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: New York, West Virginia, Pennsylvania
 Certification(s)/Specialty: Emergency Medicine

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 (IW) is a 60 year old male who sustained an industrial injury on 03/17/2014 due to bending and twisting activities while lifting on the job. He has reported back pain with spasm that causes difficulty sleeping. Diagnoses include lumbosacral radiculopathy, sprain sacra-iliac joint, and lumbosacral paravertebral spasm. Treatment s to date includes oral medications, physical therapy for the lumbar spine, modified work duties, and epidural steroid injection done 10/13/2014. In a progress note dated 10/13/2014 the treating provider reports tenderness with decreased range of motion in the back, lumbosacral spasm, positive straight leg raise, decreased sensitivity in L5-S1 dermatomes left extremity. A MRI shows degenerative disc disease and spondylolisthesis L4-5. Stenosis is present L2-13. Medications include Flexeril 7.5 mg #180, Protonix 20 mg #120, and Voltaren 100 mg #120. On 01/02/2015 Utilization Review partially certified a request for Cyclobenzaprine 7.5mg with 1 refill QTY: 90 to Cyclobenzaprine 7.5mg # 45 with no refill to allow for weaning of the medication, noting there was lack of clinical documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The MTUS Chronic Pain was cited. On 01/02/2015 Utilization Review non-certified a request for Diclofenac Sodium ER 100mg with 1 refill, QTY 60, noting the clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The MTUS Chronic Pain was cited. On 01/02/2015 Utilization Review non-certified a request for Protonix 20mg with 1 refill, QTY 60, noting the clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The MTUS Chronic Pain was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac Sodium ER 100mg with 1 refill, QTY 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 71.

Decision rationale: NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period of time in patients with moderate pain. There is no evidence supporting long term use and effectiveness. In this case, the patient has been using the medication since 9/2014, which exceeds the guidelines recommendation of short term use. In addition, there is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. Diclofenac is not medically necessary and appropriate for these reasons.

Protonix 20mg with 1 refill, QTY 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 69.

Decision rationale: Proton pump inhibitors such as Protonix are recommended for injured workers at risk for gastrointestinal bleeding, cardiovascular disease and dyspepsia. Risk factors include history of peptic ulcer and gastrointestinal bleeding. In this case, there is a lack of documentation indicating the efficacy of the medication. The clinical documentation also failed to indicate the patient had a diagnosis of dyspepsia secondary to NSAID therapy, peptic ulcer or gastrointestinal bleed. Thus, Protonix is not medically appropriate and necessary.

Cyclobenzaprine 7.5mg with 1 refill, QTY: 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 28,29.

Decision rationale: Cyclobenzaprine is recommended for short term relief (no longer than 2-3 weeks) of muscle spasms and low back pain. The maximum benefit occurs in the first 4 days. In this case, there is a lack of clinical documentation indicating the efficacy of cyclobenzaprin as evidenced by functional improvement. Furthermore the patient has been utilizing

cyclobenzaprine for an extended period of time which exceeds the guidelines recommendations of 2-3 weeks. Thus, guideline recommendations are for weaning and discontinuation of cyclobenzaprine. The requested cyclobenzaprine dose and quantity is not medically appropriate and necessary.