

<b>Case Number:</b>	CM15-0120285		
<b>Date Assigned:</b>	06/30/2015	<b>Date of Injury:</b>	02/06/2009
<b>Decision Date:</b>	08/31/2015	<b>UR Denial Date:</b>	06/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/22/2015

### 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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 is a 68 year old male, who sustained an industrial injury on 02/06/2009. According to a progress report dated 05/15/2015, the injured worker continued to have moderate lower back pain. He had a lumbar epidural injection which had given him substantial relief of his symptoms, but he stated his pain was starting to creep back in and he noted increasing stiffness in his back. His current pain level was 6 out of 10 and was sharp and intermittent. Pain level had been 8 out of 10 prior to the injection. Diagnoses included intractable lower back pain, degenerative disc disease lumbar spine, multi-level disc protrusions lumbar spine, radiculopathy on electromyography nerve conduction studies and radiculitis left lower extremity, S1 nerve root. The provider requested authorization for a repeat lumbar epidural injection. He was to see a spine surgeon for a second opinion consultation. Medications to be refilled included Diclofenac XR 100 mg #60 for anti-inflammatory and Omeprazole 20mg, #60 reduce NSAID gastritis prophylaxis 30 tabs. He was to follow up in one month for re-evaluation. He was temporarily totally disabled. His past medical history was positive for hypertension. Currently under review is the request for Diclofenac XR 100mg #60. Records show that use of Diclofenac XR dates back to 06/27/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Diclofenac XR 100mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Approach to Chronic Pain Management, Anti-inflammatories, NSAIDS Page(s): 9, 22, 67-68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Anti-inflammatory drugs, NSAIDS, Diclofenac.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines state that all therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. Guidelines state that NSAIDS are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. MTUS specific recommendations for NSAIDS include treatment of osteoarthritis for the shortest time possible and short term treatment of back pain. It may be useful for breakthrough and mixed pain conditions in patients with neuropathic pain. Other chronic pain conditions are not discussed. ODG (Official Disability Guidelines) states that anti-inflammatories are the traditional first line of treatment to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. ODG specific recommendations for NSAIDS (non-steroidal anti-inflammatory drugs) include treatment of osteoarthritis for the shortest period in patients with moderate to severe pain, for treatment in acute low back pain & acute exacerbations of chronic pain and short-term symptomatic relief of chronic low back pain. ODG Guidelines state that Diclofenac is 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 for 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 case, the injured worker had been using Diclofenac XR long-term, which is not recommended, and there was no objective evidence of functional improvement with use of Diclofenac XR. The injured worker remained temporarily totally disabled. Improvement in activities of daily living with use of Diclofenac XR were not discussed. As such the request for Diclofenac XR 100 mg #60 is not medically necessary.