

Case Number:	CM15-0173808		
Date Assigned:	09/15/2015	Date of Injury:	08/22/2014
Decision Date:	10/22/2015	UR Denial Date:	08/07/2015
Priority:	Standard	Application Received:	09/03/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 47 year old female who sustained an industrial injury on 08-22-2014. According to a progress report dated 07-28-2015, the injured worker reported dull throbbing headache that was rated 3 on a scale of 1-10. He reported sharp, stabbing neck pain, numbness and tingling radiating to the right shoulder that was rated 7. Upper and mid back pain and numbness was rated 7. Stabbing low back and numbness radiating to the bilateral legs was rated 7. Objective findings included no bruising, swelling, atrophy or lesion at the cervical, thoracic and lumbar spine. Range of motion of the lumbar spine was decreased with left and right lateral bending. Diagnoses included dizziness, headache migraine, cervical myospasm, cervical radiculopathy, cervical sprain strain rule out thoracic disc protrusion, thoracic myospasm and thoracic sprain strain. The treatment plan included continued use of Pantoprazole to protect the stomach, Cyclobenzaprine to relax the muscles and Diclofenac for pain and inflammation. Medications ordered included Tramadol. A urinalysis was performed. An authorization request dated 07-28-2015 was submitted for review. The requested services included urine toxicology, Pantoprazole, Cyclobenzaprine, Diclofenac and Tramadol. According to a chiropractic report, the injured worker was to remain off work until 08-31-2015. Records submitted for review show use of Diclofenac and Tramadol dating back to 06-26-2015 and Pantoprazole and Cyclobenzaprine dating back to 04-21-2015. Urine toxicology reports were not submitted for review. On 08-07-2015, Utilization Review non-certified the request for retrospective Cyclobenzaprine 7.5 mg, #90 twice a day retrospective Diclofenac 100 mg, #60 twice a day retrospective Pantoprazole 20 mg, #60 twice a day.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Cyclobenzaprine 7.5mg, #90 (2x a day): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: With regard to muscle relaxants, the MTUS CPMTG states: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement." Regarding Cyclobenzaprine: "Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants (e.g. amitriptyline). Cyclobenzaprine is more effective than placebo in the management of back pain, although the effect is modest and comes at the price of adverse effects." Per p 41 of the MTUS guidelines, the effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment is recommended for the treatment of acute spasm limited to a maximum of 2-3 weeks. UDS that evaluate for cyclobenzaprine can provide additional data on whether the injured worker is compliant, however in this case there is no UDS testing for cyclobenzaprine. The documentation submitted for review indicates that the injured worker has been using this medication since at least 4/2015. There is no documentation of the patients' specific functional level or percent improvement with treatment with cyclobenzaprine. As it is recommended only for short-term use, medical necessity cannot be affirmed. Therefore, the request is not medically necessary.

Retrospective Diclofenac 100mg, #60 (2x as day): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: With regard to the use of NSAIDs for chronic low back pain, the MTUS CPMTG states "Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and

acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another." "Low back pain (chronic): Both acetaminophen and NSAIDs have been recommended as first line therapy for low back pain. There is insufficient evidence to recommend one medication over the other. Selection should be made on a case-by-case basis based on weighing efficacy vs. side effect profile." The documentation submitted for review indicates that the injured worker has been treated with ibuprofen since at least 4/2015. There was no rationale provided as to why the injured worker was prescribed diclofenac. As NSAIDs are only recommended for short-term symptomatic relief, the request is not medically necessary.

Retrospective Pantoprazole 20mg, #60 (2x a day): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Proton Pump Inhibitors.

Decision rationale: In the treatment of dyspepsia secondary to NSAID therapy, the MTUS recommends stopping the NSAID, switching to a different NSAID, or considering the use of an H2-receptor antagonist or a PPI. The MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors in conjunction with NSAIDs in situations in which the patient is at risk for gastrointestinal events including: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). CPMTG guidelines further specify: "Recommendations: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.). Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk, the suggestion is naproxyn plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)" Per ODG TWC, "many prescribers believe that this class of drugs is innocuous, but much information is available to demonstrate otherwise. A trial of omeprazole or lansoprazole is recommended before Nexium therapy. The other PPIs, Protonix, Dexilant, and Aciphex, should also be second-line." While it is noted that the injured worker was being treated with NSAIDs, there is no documentation of peptic ulcer, GI bleeding or perforation, or cardiovascular disease in the records available for my review. The injured worker's risk for gastrointestinal events is low, as such, medical necessity cannot be affirmed. Furthermore, as noted per the guidelines, Protonix is a second-line medication. The medical records do not establish whether the patient has failed attempts at first line PPIs, such as omeprazole or lansoprazole, which should be considered prior to prescribing a second line PPI such as Protonix. Therefore, the request is not medically necessary.

