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| <b>Case Number:</b>   | CM15-0026846 |                              |            |
| <b>Date Assigned:</b> | 02/18/2015   | <b>Date of Injury:</b>       | 01/03/2013 |
| <b>Decision Date:</b> | 06/11/2015   | <b>UR Denial Date:</b>       | 01/20/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 02/11/2015 |

### 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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 50 year old male, who sustained an industrial injury on 1/3/13. The injured worker has complaints of lower back pain associated with tenderness, spasm, decreased sensitization and decreased range of motion. The diagnoses have included lumbosacral neuritis or radiculitis not otherwise specified and lumbar disc displacement without myelopathy. The injured worker presented on 01/15/2015 for a follow-up evaluation with complaints of 4/10 low back pain. The injured worker noted an inability to tolerate tramadol. Upon examination, there was tenderness to palpation with decreased range of motion of the lumbar spine. There was palpable muscle spasm with decreased motor strength rated 4/5 in the left lower extremity. Decreased sensation in the L5 distribution was also noted. Treatment recommendations at that time included continuation of the current medication regimen of Flexeril 7.5 mg, Protonix 20 mg, Voltaren XR 100 mg, and Norco 10/325 mg. There was no Request for Authorization form submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flexeril 7.5mg #90 times one refill: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

**Decision rationale:** The California MTUS Guidelines state muscle relaxants are recommended as non sedating second line options for short term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. The injured worker has utilized the above medication since 11/2014. The guidelines do not support long term use of this medication. There is also no frequency listed in the request. As such, the request is not medically necessary.

**Protonix 20mg #60 times one refill:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Proton Pump Inhibitors (PPI's).

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

**Decision rationale:** 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, even in addition to a nonselective NSAID. In this case, there was no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. The medical necessity for the requested medication has not been established. Additionally, there is no frequency listed in the request. As such, the request is not medically necessary.

**Voltaren 100mg #60 times one refill:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: NSAIDs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

**Decision rationale:** The California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. The injured worker has continuously utilized the above medication since 09/2014. The guidelines do not support long term use of NSAIDs. There is also no frequency listed in the request. As such, the request is not medically necessary.

**Norco 5/325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, there was no documentation of objective functional improvement despite the ongoing use of this medication. The injured worker has utilized the above medication since 02/2014. There is no documentation of a written consent or agreement for chronic use of an opioid. There is also no frequency listed in the request. As such, the request is not medically necessary.