

Case Number:	CM13-0047384		
Date Assigned:	12/27/2013	Date of Injury:	01/31/2010
Decision Date:	04/25/2014	UR Denial Date:	10/28/2013
Priority:	Standard	Application Received:	11/01/2013

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. The expert reviewer is Board Certified in Preventive Medicine, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 53-year-old female with a 1/31/10 date of injury. At the time (10/11/13) of request for authorization for Omeprazole Delayed-Release 20 mg #120, Ondansetron 8 mg #60, Cyclobenzaprine 7.5 mg #120, Terocin patch #10, and Ketoprofen capsules 75 mg #1, there is documentation of subjective (radiating neck pain, low back pain, and acute exacerbation of pain and spasms) and objective (tenderness over the cervicodorsal paravertebral muscles, pain with terminal motion with limited range of motion, positive Spurling's sign, dysesthesia at the C5 to C7 dermatomes; positive Tinel's and Phalen's sign; and tenderness over the lumbar spine with limited and guarded range of motion) findings, current diagnoses (cervical discopathy, lumbar discopathy, carpal tunnel/cubital tunnel/double crush syndrome, and status post right lateral epicondylar release), and treatment to date (medications (including ongoing treatment with Cyclobenzaprine since at least 1/24/12 and Prilosec since at least 7/31/12) and physical therapy). Medical reports identify that the patient was provided a brief course of Cyclobenzaprine in the past and noted significant improvement in the spasms; and stomach upset and epigastric pain with the use of Naproxen previously. Regarding Ondansetron 8 mg #60, there is no documentation of nausea and vomiting secondary to chemotherapy and radiation treatment, postoperative use, or acute use for gastroenteritis. Regarding Cyclobenzaprine 7.5 mg #120, there is no documentation of the intention to treat over a short course (less than two weeks); and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Cyclobenzaprine use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF OMEPRAZOLE DELAYED-RELEASE 20MG #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK,.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GI SYMPTOMS & CARDIOVASCULAR RISK Page(s): 68-69.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that risk for gastrointestinal event includes age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; and/or high dose/multiple NSAID. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of risk for gastrointestinal events, preventing gastric ulcers induced by NSAIDs, as criteria necessary to support the medical necessity of Protonix. Within the medical information available for review, there is documentation of diagnoses of cervical discopathy, lumbar discopathy, carpal tunnel/cubital tunnel/double crush syndrome, and status post right lateral epicondylar release. In addition, there is documentation of ongoing treatment with Prilosec since at least 7/31/12. Furthermore, there is documentation of stomach upset and epigastric pain with the use of Naproxen previously. Therefore, based on guidelines and a review of the evidence, the request for Omeprazole Delayed-Release 20 mg #120 is medically necessary.

PRESCRIPTION FOR ONDANSETRON 8MG #60: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), PAIN CHAPTER, ANTIEMETICS (FOR OPIOID NAUSEA).

Decision rationale: MTUS does not address the issue. ODG identifies documentation of nausea and vomiting secondary to chemotherapy and radiation treatment, postoperative use, or acute use for gastroenteritis, as criteria necessary to support the medical necessity of Ondansetron (Zofran). Within the medical information available for review, there is documentation of diagnoses of cervical discopathy, lumbar discopathy, carpal tunnel/cubital tunnel/double crush syndrome, and status post right lateral epicondylar release. However, there is no documentation of nausea and vomiting secondary to chemotherapy and radiation treatment, postoperative use, or acute use for gastroenteritis. Therefore, based on guidelines and a review of the evidence, the request for Ondansetron 8 mg #60 is not medically necessary.

PRESCRIPTION FOR CYCLOBENZAPRINE 7.5MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CYCLOBENZAPRINE Page(s): 41-42. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN, MUSCLE RELAXANTS (FOR PAIN).

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that Flexeril is recommended for a short course of therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of cervical discopathy, lumbar discopathy, carpal tunnel/cubital tunnel/double crush syndrome, and status post right lateral epicondylar release. In addition, there is documentation of acute exacerbation of pain and spasms. However, given documentation of records reflecting prescriptions for Cyclobenzaprine since at least 7/31/12, there is no documentation of the intention to treat over a short course (less than two weeks). In addition, despite documentation of significant improvement in the spasms with course of Cyclobenzaprine in the past, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Cyclobenzaprine use to date. Therefore, based on guidelines and a review of the evidence, the request for Cyclobenzaprine 7.5 mg #120 is not medically necessary.

PRESCRIPTION FOR TEROGIN PATCH #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

Decision rationale: Terocin is a topical pain relief lotion that contains Methyl Salicylate, Capsaicin, Menthol, and Lidocaine. MTUS Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that Ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other ant epilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Within the medical information available for review, there is documentation of diagnoses of cervical discopathy, lumbar discopathy, carpal tunnel/cubital tunnel/double crush syndrome, and status post right lateral epicondylar release. However, Terocin contains at least one drug (lidocaine) that is not

recommended. Therefore, based on guidelines and a review of the evidence, the request for Terocin patch #10 is not medically necessary.

PRESCRIPTION FOR KETOPROFEN CAPSULES 75MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (NON-STEROIDAL ANTI-INFLAMMATORY DRUGS) Page(s): 67.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NON-STEROIDAL ANTI-INFLAMMATORY DRUGS Page(s): 67-68.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe osteoarthritis pain, acute low back pain, chronic low back pain, or exacerbations of chronic pain, as criteria necessary to support the medical necessity of NSAIDs. Within the medical information available for review, there is documentation of diagnoses of cervical discopathy, lumbar discopathy, carpal tunnel/cubital tunnel/double crush syndrome, and status post right lateral epicondylar release. In addition, there is documentation of subjective findings (radiating neck pain, low back pain, and acute exacerbation of pain and spasms). However, given documentation of the requested Ketoprofen capsules 75 mg #1, there is no documentation of the quantity requested. Therefore, based on guidelines and a review of the evidence, the request for Ketoprofen capsules 75 mg #1 is not medically necessary.