

Case Number:	CM13-0067161		
Date Assigned:	01/03/2014	Date of Injury:	02/24/2006
Decision Date:	06/16/2014	UR Denial Date:	11/29/2013
Priority:	Standard	Application Received:	12/17/2013

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 Occupational 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:

The patient is a [REDACTED] employee who has filed a claim for lumbar spondylolisthesis and left leg radiculopathy associated with an industrial injury date of February 24, 2006. Thus far, the patient has been treated with physical therapy, Toradol injections, B12 injections, and L4-S1 posterior lumbar interbody fusion with symptomatic hardware and failed back syndrome. Current medications were not indicated. A review of progress notes from 2013 indicates continued low back pain radiating to the left more than the right lower extremity with associated numbness and tingling. Findings include tenderness over the lumbar region with transient extension of pain to the L4-5 and L5-S1 dermatomes. A lumbar x-ray from October 22, 2013 showed post-fusion hardware with halo and osteolysis from the screws at L4-5. A lumbar MRI dated November 03, 2011 showed multi-level degenerative changes and post-fusion changes. Bilateral lower extremity EMG/NCS from October 31, 2011 showed active L5 bilateral lumbosacral radiculopathy. Utilization review dated November 29, 2013 indicates that the claims administrator denied a request for Cyclobenzaprine 7.5mg #120 as there is no documentation of acute exacerbations; Ondansetron ODT 8mg #60 as there is no documentation of nausea or vomiting, or post-operative state, chemotherapy, or radiation; omeprazole DR 20mg #120 as patient does not have GI risk factors; Tramadol ER 150mg #90 as it is not a first-line medication; and Terocin patch #10 as it is not recommended for use.

IMR ISSUES, DECISIONS AND RATIONALES

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

CYCLOBENZAPRINE HCL 7.5MG, #120: Upheld

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

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

Decision rationale: As stated in the MTUS Chronic Pain Guidelines page 63, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. They may be effective in reducing pain and muscle tension, and increasing mobility. However, they show no benefit beyond NSAIDs in pain and overall improvement. The patient has been on this medication since January 2013 and this medication is not recommended for long-term use. It was not indicated whether use of this medication was continuous or there were periods of discontinuation. Also, there is no documentation of acute exacerbation of pain or muscle spasms. Therefore, the request for 120 Cyclobenzaprine Hydrochloride tablets, 7.5mg is not medically necessary and appropriate.

ONDANSETRON ODT 8MG, #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation PER DAILY MED (<http://dailymed.nlm.nih.gov.dailymed/druginfo>)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OTHER MEDICAL TREATMENT GUIDELINE OR MEDICAL EVIDENCE: FDA (ONDANSETRON)

Decision rationale: The MTUS Guidelines does not address this topic. The FDA recommends the use of Ondansetron for prevention of nausea and vomiting caused by cancer chemotherapy, radiation therapy, and surgery. There is no documentation within the medical records provided for review that this patient has nausea or vomiting related to chemotherapy, radiotherapy, or surgery. Therefore, the request is not medically necessary and appropriate.

OMEPRAZOLE ODT 20MG, #120: Upheld

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

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

Decision rationale: According to the MTUS Chronic Pain Guidelines, proton pump inhibitors are used in patients on NSAID therapy who are at risk for GI events. Risk factors include age > 65; history of peptic ulcer, GI bleed, or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; and high dose or multiple NSAID use. Use of PPI > 1 year has been shown to increase the risk of hip fracture. The patient has been on this medication since January 2013.

Although the patient is on NSAIDs, there is no documentation of GI risk factors in this patient. Also, this medication is not recommended for long-term use. Therefore, the request is not medically necessary and appropriate.

TRAMADOL HCL ER 150MG, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-81.

Decision rationale: As noted on pages 76-81 of the MTUS Chronic Pain Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. A therapeutic trial of opioids is recommended in cases that the patient has failed a trial of non-opioid analgesics, and goals of therapy and baseline pain and functional assessments should be documented. In this case, there is no documentation of the patient's current medication regimen. There is no documentation regarding failure of NSAID therapy to support addition of an opioid to the treatment regimen. Therefore, the request is not medically necessary.

TEROCIN PATCH, #10: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 28, 105, 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: Terocin contains 4 active ingredients; Capsaicin in a 0.025% formulation, Lidocaine in a 2.50% formulation, Menthol in a 10% formulation, and Methyl Salicylate in a 25% formulation. The MTUS Chronic Pain Guidelines page 111 state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Regarding the Capsaicin component, the MTUS Chronic Pain Guidelines on page 28 states that topical Capsaicin is only recommended as an option when there was failure to respond or intolerance to other treatments; with the 0.025% formulation indicated for osteoarthritis. Regarding the Lidocaine component, the MTUS Chronic Pain Guidelines identify on page 112 that topical formulations of lidocaine (whether creams, lotions or gels) are not indicated for neuropathic or non-neuropathic pain complaints. Regarding the Menthol component, the ODG states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, methyl salicylate, or capsaicin, may in rare instances cause serious burns. Regarding the Methyl Salicylate component, the MTUS Chronic Pain Guidelines states that salicylate topicals are significantly better than placebos in treating chronic pain. There is no rationale as to the necessity of a topical medication in this patient, and Guideline recommendations state that lidocaine is not indicated for topical application. Therefore, the request is not medically necessary and appropriate.

