

<b>Case Number:</b>	CM13-0068787		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	04/03/2006
<b>Decision Date:</b>	05/29/2014	<b>UR Denial Date:</b>	11/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/20/2013

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 injured worker is a 40-year-old male who reported an injury on 04/03/2006. The mechanism of injury was not stated. Current diagnoses include status post C3-6 hybrid reconstruction and rule out double-crush syndrome. The injured worker was evaluated on 01/21/2014. The injured worker reported persistent neck pain with radiation to bilateral upper extremities. Physical examination revealed tenderness to palpation of the cervical spine with upper trapezial muscle spasm, limited range of motion, and dysesthesia in the upper extremities. Treatment recommendations at that time included continuation of current medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NAPROXEN 550 MG #100:** Upheld

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

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

**Decision rationale:** Chronic Pain Medical Treatment Guidelines state (NSAIDs) non-steroidal anti-inflammatory drugs 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 treatment after acetaminophen. As per the documentation submitted, the injured worker has utilized Naproxen 550 mg since 05/2013. There is no evidence of objective functional improvement as a result of the ongoing use of this medication. There is also no frequency listed in the current request. As such, the request is not medically necessary and appropriate.

**OMEPRAZOLE 20 MG #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009).

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

**Decision rationale:** Chronic Pain Medical Treatment 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. There is no mention of cardiovascular disease or increased risk factors for gastrointestinal events. There is also no frequency listed in the current request. Therefore, the request is not medically necessary and appropriate.

**CYCLOBENZAPRINE 7.5 MG #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181.

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

**Decision rationale:** Chronic Pain Medical Treatment Guidelines state muscle relaxants are recommended as non-sedating second-line options for short-term treatment of acute exacerbations. The injured worker has utilized Cyclobenzaprine 7.5 mg since 03/2013. Chronic Pain Medical Treatment Guidelines further state Cyclobenzaprine should not be used for longer than 2 to 3 weeks. Despite ongoing use of this medication, the injured worker continues to report palpable muscle spasm. There is also no frequency listed in the current request. As such, the request is not medically necessary and appropriate.

**ONDANSETRON ODT 8 MG #60: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Editorial Board Palliative Care: Practice Guidelines, Nausea and Vomiting. Utrecht, The Netherlands; Association of Comprehensive Cancer Center (ACCC); 2006 Jan 12. 28 p.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Ondansetron, Antiemetic.

**Decision rationale:** Official Disability Guidelines state Ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. Ondansetron has been FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment, and for postoperative use. The injured worker does not meet criteria for the requested medication. There is also no frequency listed in the current request. As such, the request is not medically necessary and appropriate.

**TEROCIN PATCHES #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): 111-113.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no mention of a failure to respond to first-line oral medication prior to initiation of a topical analgesic. There is also no frequency listed in the current request. As such, the request is not medically necessary and appropriate.

**TRAMADOL ER 150 MG #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): 74-82.

**Decision rationale:** Chronic Pain Medical Treatment 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. The injured worker has utilized Tramadol ER 150 mg since 03/2013. Despite ongoing use of this medication, the injured worker continues to report increasing pain. There is also no frequency listed in the current request. As such, the request is not medically necessary and appropriate.