

Case Number:	CM14-0002199		
Date Assigned:	01/24/2014	Date of Injury:	05/30/2010
Decision Date:	06/19/2014	UR Denial Date:	12/31/2013
Priority:	Standard	Application Received:	01/07/2014

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 Anesthesiology, has a subspecialty in Pain Management 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 an employee of [REDACTED] who has submitted a claim for depressive disorder, and lumbar radiculopathy status post lumbar fusion, associated with an industrial injury date of 05/30/2010. Treatment to date has included lumbar L4-S1 fusion in October 2013; lumbar spine exploration with incision, drainage, and debridement on 11/10/2013; physical therapy, chiropractic care, lumbar epidural steroid injections, left knee surgery in 2011, right knee arthroscopy in June 2013, and medications such as, IM Depo-Medrol, IM Vitamin B12 complex, naproxen, omeprazole, ondansetron, cyclobenzaprine, tramadol, quazepam, levofloxacin, Dilaudid, Vicodin, and Sumatriptan. Medical records from 2013 were reviewed showing that patient complained of persistent low back pain and bilateral knee pain. Physical examination revealed tenderness of the paralumbar area. Pain was present with terminal motion. Seated nerve root test was positive. Motor strength was 3-/5 in the L5 and S1 myotomes. Sensation was diminished at L5 and S1 dermatomes. Examination of the right knee showed minimal swelling and pain upon terminal flexion. The left knee showed tenderness at the joint line, positive McMurray's sign, positive patellar compression test, and pain upon terminal flexion. Patient underwent lumbar L4-S1 fusion in October 2013. He was status quo post-operatively until two weeks later, there was progressive amount of drainage from the wound. He likewise complained of worsening back pain associated with bilateral lower extremity weakness. He was initially managed with oral antibiotics, however, persistence of symptoms prompted lumbar spine exploration with debridement on 11/10/2013. Patient received the following medications while admitted: PCA Dilaudid, IV Pepcid, IV Ancef, and Vancomycin. Utilization review from 12/31/2013 denied the requests for ondansetron ODT tablets 8mg, #30 x 2 Qty 60 because there were no findings noted pertaining to nausea or vomiting; naproxen 550mg, #100 because it is not recommended for long-term use. The request for Cyclobenzaprine 7.5mg, #120

was modified into #60 because it is only recommended for short-term therapy. Quazepam 15mg, Qty 30 was modified into #15 for weaning purposes. The requests for Omeprazole 20mg, #120; Levofloxacin 750mg, #30; Tramadol ER 150mg, #90; and Terocin patch, Qty 10 were likewise denied, however, reasons for denial were not made available.

IMR ISSUES, DECISIONS AND RATIONALES

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

Med Cyclobenzaprine Hydrochloride 7.5mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41, 64.

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

Decision rationale: According to page 63 of the CA MTUS Chronic Pain Medical Treatment Guidelines, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In this case, patient has been on cyclobenzaprine since May 2013, which is beyond the recommended duration of use. Furthermore, the most recent progress report, dated 12/10/2013 did not show presence of muscle spasm. The medical necessity has not been established. Therefore, the request for Med Cyclobenzaprine Hydrochloride 7.5mg #120 is not medically necessary.

Ondansetron ODT Tablets 8mg #30 X2 QTY 60: Upheld

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

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) and Ondansetron

Decision rationale: The CA MTUS does not address Ondansetron specifically. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Pain Chapter, Antiemetics (for opioid nausea) and Ondansetron was used instead. ODG states that Ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. In this case, Ondansetron was prescribed since May 2013 as treatment for nausea associated with opioid use. Patient likewise underwent lumbar wound debridement in 11/10/2013, and was on PCA Dilaudid. However, medical records submitted and reviewed do not provide evidence for any subjective complaints of nausea and vomiting. There is no documented indication for this medication. Therefore, the request for Ondansetron ODT Tablets 8MG #30 X2 QTY 60 is not medically necessary.

Naproxen Sodium Tablets 550mg #100: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66, 73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

Decision rationale: As stated on page 46 of the California MTUS Chronic Pain Medical Treatment guidelines, Non-Steroidal Anti-Inflammatory Drugs (NSAID) are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and that there is no evidence of long-term effectiveness for pain or function. In this case, patient recently underwent lumbar spine debridement for wound drainage on 11/10/2013. There is current acute exacerbation of back pain related to the surgery involved. The most recent physical examination revealed tenderness and minimal swelling. A prescription of NSAID may be supported in this case. Therefore, the request for Naproxen Sodium Tablets 550mg #100 is medically necessary.

Omeprazole Delayed-Release Capsules 20mg #120: Upheld

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

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

Decision rationale: As stated on page 68 on CA MTUS Chronic Pain Medical Treatment Guidelines, clinicians should weigh the indications for Non-Steroidal Anti-Inflammatory Drugs (NSAID) against both Gastrointestinal (GI) and cardiovascular risk factors: history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; or on high-dose/multiple NSAIDs. Patients with intermediate risk factors should receive a proton pump inhibitor. In this case, patient has been on omeprazole since May 2013. He is likewise on naproxen and opioids. However, the medical records submitted and reviewed did not mention that patient had gastrointestinal distress associated with medication intake. He likewise does not meet any of the aforementioned risk factors. Therefore, the request for Omeprazole delayed-release capsules 20mg #120 is not medically necessary.

Levofloxacin 750mg #30: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.nlm.nih.gov/medlineplus/antibiotics.html>

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: Physician's Desk Reference 2014, Levofloxacin.

Decision rationale: The CA MTUS does not address Levofloxacin specifically. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and The Physician's Desk Reference 2014 was used. The Physician's Desk Reference 2014 states that Levofloxacin is an antibiotic used to treat a variety of infections. In this case, the patient underwent lumbar fusion surgery in October 2013, however the presence of purulent drainage at operative site prompted incision, drainage, and debridement in November 2013. A prescription of antibiotic is necessary in this case to address post-operative infection. Therefore, the request for Levofloxacin 750mg #30 is medically necessary.

Terocin Patch QTY 10: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

Decision rationale: Terocin patch is composed of 4% mentol, and 4% lidocaine. As stated on page 112 of CA MTUS Chronic Pain Medical Treatment Guidelines, lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (i.e., antiepileptic drug, and antidepressants). Lidocaine in a dermal patch has been approved for neuropathic pain. Regarding the Menthol component, CA MTUS does not cite specific provisions, but the ODG Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, may in rare instances cause serious burns. In this case, patient has persistent low back pain radiating to bilateral lower extremities despite treatment with multiple oral medications, including a benzodiazepine. Transdermal formulation may be necessary as adjuvant treatment to limit adverse effects from oral medications. The medical necessity has been established. Therefore, the request for Terocin Patch QTY 10 is medically necessary.

Quazepam 15mg CIV QTY 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

Decision rationale: As stated on page 24 of the California MTUS Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because of unproven long-term efficacy and risk of dependence; use is limited to 4 weeks. In this case, patient has been on Quazepam since May 2013, as needed for sleep. However, the frequency of actual intake was not documented. Furthermore, there is no documentation concerning the treatment plan for this medication. This is not recommended for long-term use. Therefore, the request for Quazepam 15mg CIV QTY 30 is not medically necessary.

Tramadol Hydrochloride ER 150mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78, 93-94, 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

Decision rationale: Page 78 of the CA MTUS Chronic Pain Medical Treatment Guidelines states that ongoing opioid treatment should include monitoring of analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors; these outcomes over time should affect the therapeutic decisions for continuation. In this case, the patient has been taking this medication since May 2013. However, there is no documentation concerning objective pain relief or functional improvement from the use of this medication. CA MTUS requires clear and concise documentation for continuing opioid management. Therefore, the request for Tramadol Hydrochloride ER 150MG #90 is not medically necessary.