

Case Number:	CM14-0100596		
Date Assigned:	07/30/2014	Date of Injury:	06/06/2012
Decision Date:	09/03/2014	UR Denial Date:	06/03/2014
Priority:	Standard	Application Received:	06/30/2014

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 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 53 year old male who is reported to have a date of injury of 08/06/12. The mechanism of injury is not described. The injured worker was reported to have low back pain with radiation to the bilateral lower extremities. The clinical records report that the injured worker has failed conservative management which has included activity modifications, 10 physical therapy sessions, 3 lumbar epidural steroid injections, and trigger point injections. The record includes an EMG/NCV study dated 12/23/13 which is negative for lower extremity radiculopathy. On physical examination at this time, motor strength and sensation were intact. Per a clinical note dated 06/16/14, it is reported that the injured worker has decreased range of motion, weakness, pain, and sensory loss in an L4-5 and L5-S1 distribution. Per this note, the injured worker has been recommended to undergo an L4 through S1 PLIF. The record includes an MRI of the lumbar spine dated 03/14/14. This study notes no substantive abnormalities at L1-2 or L2-3. At L3-4, there is a 3mm posterior disc protrusion. There is an annular tear in relation to the far right posterolateral aspect of the disc. There is no compromise of the traversing nerve roots. There is encroachment on the foramina with compromise of the exiting nerve roots bilaterally. At L4-5, disc height and signal are maintained. There is a 3mm posterior disc protrusion. There is an annular tear identified in relation to the far right posterolateral aspect of the disc. There is contact of the thecal sac. There is no compromise of the traversing nerve roots. There is encroachment on the foramina with compromise of the exiting nerve roots bilaterally. At L5-S1, the disc height is maintained. There is partial desiccation of the disc. There is a 3mm posterior disc bulge which encroaches on the epidural fat. There is an annular tear noted in relation to the left posterolateral aspect of the disc as well as the right posterolateral aspect of the disc. There is no compromise of the traversing nerve roots. There is encroachment of the foramina with compromise of the exiting right nerve root but not the exiting left nerve

root. There is no evidence of instability reported on this study. The record includes a utilization review determination dated 06/03/14 in which requests for Ondansetron 8mg #60, Orphenadrine Citrate 100mg #120, Sumatriptan Succinate 25mg #18, and Terocin patch #30 were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 Ondansetron 8mg (██████████): Upheld

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

Decision rationale: The submitted clinical records indicate that the injured worker has complaints of low back pain with radiation to the bilateral lower extremities. The record provides no data to establish that the injured worker has NSAID or medication induced gastritis for which this medication would be clinically indicated. Further, per the Official Disability Guidelines, Zofran is approved for nausea and vomiting secondary to chemotherapy and radiation treatment or for postoperative use. As the injured worker fails to meet any of the criteria, the request is not medically necessary.

120 Orphenadrine Citrate 100mg (██████████): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: The submitted clinical records indicate that the injured worker has complaints of low back pain with radiation to the bilateral lower extremities. The injured worker is noted to have decreased range of motion on physical examination. The record does not provide any data indicating that the injured worker has active myospasms for which this medication would be indicated. Further, CA MTUS does not support the prolonged use of muscle relaxants in the treatment of chronic back pain. Therefore the request is not medically necessary.

18 Sumatriptan Succinate 25mg (██████████): Upheld

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

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

Decision rationale: The submitted clinical records do not provide any data which indicates that the injured worker suffers from migraine headaches for which this medication would be indicated. Given the lack of clinical information, the medical necessity for this medication has not been established. The request for Sumatriptan Succinate 25mg #18 is not supported as medically necessary

30 Terocin Patch ([REDACTED]): Upheld

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

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

Decision rationale: The submitted clinical records indicate that the injured worker has complaints of low back pain with radiation into the bilateral lower extremities. The record does not detail the injured worker's visual analog scale scores or response to prior prescriptions of this medication. Both CA MTUS and Official Disability Guidelines do not support the use of topical analgesics noting that these medications are largely experimental and investigational due to the lack of high quality peer reviewed studies to establish the efficacy. The request for Terocin patch #30 is not medically necessary.