

<b>Case Number:</b>	CM14-0106957		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	10/21/2009
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	06/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 female with a reported injury on 10/21/2009. She acquired her injury due to cumulative trauma. Her diagnoses consisted of low back pain, chronic and multilevel disc disease. She has had previous treatments of injections and a home exercise program. The injured worker had an examination on 04/30/2014 with complaints of ongoing constant back pain. The physician noted the injured worker had lumbar spine spasms, a positive straight leg raise, and decreased range of motion. The list of medications provided includes Norflex, Ondansetron, Omeprazole, Tramadol, Terocin patches. The recommended plan of treatment was to refer the injured worker to a doctor for another rhizotomy and renew her medications. The Request for Authorization for the medications was signed and dated 06/09/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Terocin Patch #30:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines do not recommend any compounded product that contains at least 1 drug or drug class that is not recommended. Terocin patches are comprised of menthol and Lidocaine. The guidelines note Lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. Topical Lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain and no other commercially approved topical formulations of Lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. There is a lack of documentation of a clinical examination to indicate that this injured worker has neuropathic pain. It is unknown as to how long the injured worker has been prescribed this medication. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. The guidelines do not recommend the use of Lidocaine for topical application in forms other than Lidoderm. Furthermore, the request does not specify directions as far as frequency, duration and placement as to where the patch is to be placed. Therefore, the request for Terocin Patch #30 is not medically necessary and appropriate.

**Orphenadrine citrate ER 100 mg #20:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants, antispasmodics Page(s): 64-65.

**Decision rationale:** The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. There is a lack of documentation indicating the injured worker has significant muscle spasms upon physical examination. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. Within the documentation the physician did not indicate how long the injured worker has been prescribed this medication. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. Therefore, the request for Orphenadrine citrate ER 100 mg #20 is not medically necessary and appropriate.

**Ondansetron ODT 8 mg #30 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 67 & 68.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Antiemetics (for opioid nausea).

**Decision rationale:** The Official Disability Guidelines recommend Antiemetics for nausea and vomiting secondary to chemotherapy and radiation treatment, as well as for postoperative use and for acute gastritis. The guidelines do not recommend the use of Antiemetics for nausea and vomiting secondary to chronic opioid use. There is a lack of documentation indicating the injured worker has any gastrointestinal issues or reported any as nausea and/or vomiting. There is no indication that the injured worker is receiving chemotherapy or radiation. There is no indication that the medication is being used postoperatively. Furthermore, the request does not specify directions, as far as duration and frequency and there is a lack of evidence to support the number of 30 pills with 2 refills without further evaluation and assessment. Therefore, the request for Ondansetron ODT 8 mg #30 with 2 refills is not medically necessary and appropriate.

**Omeprazole Delayed Release Capsule, 20 mg, #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 67 & 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID, GI Symptoms and cardiovascular risk Page(s): 68.

**Decision rationale:** The California MTUS guidelines recommend the use of a proton pump inhibitor (such as Omeprazole) for injured workers at intermediate risk for gastrointestinal events with no cardiovascular disease and injured workers at high risk for gastrointestinal events with no cardiovascular disease. The guidelines note injured workers at risk for gastrointestinal events include injured workers over 65 years of age, injured workers with a history of peptic ulcer, GI bleeding or perforation, with concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). There is no evidence that the injured worker has reported any gastrointestinal issues. There is no evidence that the injured worker is at risk for gastrointestinal events. The injured worker does not have a history of peptic ulcers, gastrointestinal bleed or perforation. The injured worker is not utilizing aspirin, corticosteroids or anticoagulants concurrently, and she is not prescribed high doses of NSAIDs or multiple NSAIDs. Furthermore, the request does not specify directions as far as frequency and duration and there is a lack of evidence to support the number of 120 pills without further evaluation and assessment. Therefore, the request for Omeprazole Delayed Release Capsule, 20 mg, #120 is not medically necessary and appropriate.

**Naproxen Sodium 550 mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 67 & 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68,73.

**Decision rationale:** The California MTUS Guidelines recommend NSAIDs as an option for short term symptomatic relief of back pain. Naproxen is generally recommended for diagnoses of osteoarthritis or ankylosing spondylitis. The guidelines recommend a dose of 250-500 mg

twice per day. The physician is requesting 550 mg, which is not consistent with the guideline recommendations. Furthermore, the request does not specify directions as far as frequency and duration and there is a lack of evidence to support the number of 120 pills without further evaluation and assessment. Therefore, the request for Naproxen Sodium 550 mg, #120 is not medically necessary and appropriate.