

Case Number:	CM14-0109703		
Date Assigned:	08/01/2014	Date of Injury:	06/18/2012
Decision Date:	09/10/2014	UR Denial Date:	06/16/2014
Priority:	Standard	Application Received:	07/14/2014

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 and Rehabilitation 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 injured worker is a 57-year-old male who reported an injury on 06/18/2012, due to unknown mechanism. The injured worker's diagnosis was lumbago. The injured worker's past diagnostics include x-ray of the lumbar spine dated 01/02/2014 that revealed implant hardware failure. The injured worker had a posterior lumbar interbody fusion from L4 to S1. The injured worker complained of constant back pain. On objective examination dated 06/18/2014, there was palpable paravertebral muscle tenderness with spasm, with restricted and guarded flexion, and extension. The injured worker medications were Ondansetron, Omeprazole, Orphenadrine, Tramadol, and Terocin patch. The provider's treatment plan was to continue with medications, physical therapy, manipulation, acupuncture. The requested treatment plan is for Ondansetron ODT 8 mg, Omeprazole DR 20 mg, Orphenadrine citrate ER, and Tramadol ER, and Terocin patches. The rationale for the request was not provided with documentation. The request for authorization form was not provided with documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ondansetron ODT 8mg #30: Upheld

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

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.

Decision rationale: The request for Ondansetron ODT 8mg #30 is not medically necessary. According to the Official Disability Guidelines (ODG), antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. Recommended for acute use per FDA approved indications. Nausea and vomiting is common with use of opioids. These side effects tend to diminish over days to weeks of continued exposure. Study of opioid adverse effects include nausea and vomiting are limited to short-term duration, usually less than 4 weeks, and have limited application for long-term use. If nausea and vomiting remain for longer, etiologies of these symptoms should be evaluated for. There is documentation within the medical record submitted that indicates the injured worker has been on medication, and there is lack of documentation that indicates the efficacy of the medication that would warrant continued use. In addition there is lack of documentation in the clinical medical record indicating that the injured worker had complaints of nausea and vomiting symptoms. In the absence of this documentation, the request is not supported by evidence based guidelines. Additionally, the request failed to include the frequency of the proposed medication. Therefore, the request is not medically necessary.

Omeprazole DR 20mg #120: Upheld

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

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

Decision rationale: The request for Omeprazole DR 20mg #120 is not medically necessary. The California MTUS Chronic Pain Guidelines state that proton pump inhibitors may be recommended to treat dyspepsia secondary to NSAID therapy. Addition of a proton pump inhibitor is also supported for patients taking NSAID medications that have cardiovascular disease or are at a significant risk for a gastrointestinal event. There is no documentation indicating that the injured worker had complaints of any nausea and vomiting with the use of this medication with no significant risk of gastrointestinal event. In the absence of this documentation, the request is not supported by guidelines. Additionally, the request failed to include the frequency of the medication. As such, the request for Omeprazole DR 20mg #120 is not medically necessary.

Orphenadrine Citrate ER 100mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

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

Decision rationale: The request for Orphenadrine Citrate ER 100 mg #120 is not medically necessary. The California MTUS Chronic Pain Guidelines recommend muscle relaxants with causation as a second line option for short-term treatment of acute exacerbation in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility; however, in most low back pain cases, they show no benefits beyond an NSAID in pain and overall improvement. Efficacy of muscle relaxants appear to diminish over time and prolonged use of some medications in this class may lead to dependence. The clinical documentation submitted for review objective noted was tenderness at the lumbar spine with pain with decreased range of motion with range of motion intact. There is lack of documentation in the clinical record indicating the efficacy of this medication. In the absence of this documentation, the request is not supported by guidelines. Additionally, the request failed to include the frequency of the medication. As such, the request for Orphenadrine Citrate ER 100mg #120 is not medically necessary.

Tramadol ER 150mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management, page(s) 78 Page(s): page(s) 78.

Decision rationale: The request for Tramadol ER 150 mg, #90 is not medically necessary. The California MTUS Guidelines recommend the documentation of pain relief, functional status, appropriate medication use, and side effects. Guidelines also recommend the use of urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The provider failed to document a complete and adequate pain assessment. There is lack of documentation of the efficacy of the medication. Additionally, the use of urine drug screen was not provided in the documentation for review. Frequency of the medication was not provided for the proposed request. As such, the request for Tramadol ER 150mg #90 is not medically necessary.

Terocin Patches #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics page(s) 111-112 Page(s): page(s) 111-112.

Decision rationale: The request for Terocin Patches #30 is not medically necessary. According to the California MTUS, 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. The injured worker complained of low back pain in the most current clinical visit. The proposed patch contains Lidocaine and Lidocaine is indicated for neuropathic pain and recommended for

localized peripheral pain after there has been evidence of a first line therapy. Topical Lidocaine in the form of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. There should be documented evidence of a first line therapy to include antidepressants and/or an antiepileptic drug such as Gabapentin or Lyrica. The injured worker complained of constant low back pain per documentation submitted for review. There is lack of documentation of a trial of first line therapy such as antidepressants and/or antiepileptic drugs. There is absence of this documentation and additionally the request failed to mention the body part to which the patch is to be applied as well as the frequency. As such, the request is not medically necessary.