

Case Number:	CM14-0017738		
Date Assigned:	04/16/2014	Date of Injury:	06/27/2011
Decision Date:	06/30/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	02/12/2014

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 Pain Management, has a subspecialty in Interventional Spine 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 a 41 year old male with an injury date of 06/27/11. Based on the 11/22/13 progress report provided by [REDACTED], the patient complains of persistent pain of the lower back that is aggravated by bending, lifting, twisting, pushing, pulling, sitting, standing, and walking blocks. Examination of the lumbar spine reveals tenderness from the mid to distal lumbar segments. There is pain with terminal motion and neurovascular status remains intact. The patient is temporarily totally disabled. The patient's diagnoses include the following: 1. Status post L4 to S1 posterior lumbar interbody fusion (date not provided) 2. Retained symptomatic lumbar spinal hardware [REDACTED] is requesting for the following: 1. Cyclobenzaprine Hydrochloride Tablets 7.5 mg #120 2. Ondansetron ODT Tablets 8 mg #30 X 2 3. Tramadol Hydrochloride ER 150 mg #90 4. Teracin Patch QTY: 10 The utilization review determination being challenged is dated 01/17/14 and recommends denial of the Cyclobenzaprine Hydrochloride, Ondansetron, Tramadol Hydrochloride, and Teracin Patch. [REDACTED] is the requesting provider, and he provided two treatment reports from 11/22/13 and 01/27/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

CYCLOBENZAPRINE HYDROCHLORIDE TABLETS 7.5MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines-Treatment for Workers' Compensation (TWC).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN) Page(s): 63-66.

Decision rationale: According to the 11/22/13 progress report by [REDACTED], the patient presents with chronic low back pain. The request is for Cyclobenzaprine Hydrochloride Tablets 7.5 mg #120. The treating physician did not provide the report with the request, nor did any of the two reports provided mention Cyclobenzaprine Hydrochloride. A prescription note from 12/09/13 shows that the patient was taking this medication. It is unknown if the patient has previously taken this medication and if so, how long the patient has been taking it for. MTUS guidelines state that Cyclobenzaprine are "not recommended to be used for longer than 2-3 weeks." Reviewing the records, there is no indication of how long the patient has been taking Cyclobenzaprine Hydrochloride nor what the medication did for the patient's pain. The request is not medically necessary and appropriate.

ONDANSETRON ODT TABLETS 8MG #30 X2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: According to the 11/22/13 progress report by [REDACTED], the patient presents with chronic low back pain. The request is for Ondansetron ODT Tablets 8 mg #30 X 2. The report with the request was not provided. The MTUS and ACOEM Guidelines do not discuss Ondansetron. However, ODG Guidelines has the following regarding antiemetics, "Not recommended for nausea and vomiting secondary to chronic opioid use. Recommended for acute use as noted below per FDA-approved indications." "Ondansetron (Zofran): This drug is a serotonin 5-HT₃ receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use. Acute use is FDA-approved for gastroenteritis." None of the two reports provided any documentation that the patient has nausea and vomiting or post-operative. The request is not medically necessary and appropriate.

TRAMADOL HYDROCHLORIDE 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 Medications For Chronic Pain Page(s): 60-61.

Decision rationale: According to the 11/22/13 progress report by [REDACTED], the patient presents with chronic low back pain. The request is for Tramadol Hydrochloride ER 150 mg #90. Review of the reports show the patient has been taking Tramadol since 12/09/13. For long-term use of opiates MTUS guidelines require documentation of pain and function. Numeric scale or a validated instrument is required once every 6 months to document function. The guidelines also require addressing the four A's (analgesia, ADL's, adverse effects and adverse events). In this case, documentation is inadequate. No numerical scales are provided, and no specifics are provided regarding functional changes in either of the two reports provided. The request is not medically necessary and appropriate.

TERACIN PATCH QTY 10: 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): 56-57, 111-113.

Decision rationale: According to the 11/22/13 progress report by [REDACTED], the patient presents with chronic low back pain. The request is for Teracin Patch QTY: 10. Terocin patches are a dermal patch with 4% Lidocaine, and 4% Menthol. MTUS for topical Lidocaine states: "Indication: Neuropathic pain Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or Serotonin-norepinephrine reuptake inhibitors (SNRI) anti-depressants or an Anti-Epilepsy Drugs (AEDs) such as Gabapentin or Lyrica)." In this case, there is no evidence that the patient has previously had a trial of first-line therapy. Furthermore, Lidocaine is recommended for neuropathic pain that is peripheral and localized. This patient suffers from chronic low back pain. The request is not medically necessary and appropriate.