

Case Number:	CM14-0018602		
Date Assigned:	04/18/2014	Date of Injury:	05/26/1987
Decision Date:	08/05/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	02/13/2014

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 Occupational Medicine 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 51-year-old male who has filed a claim for lumbar discopathy associated with an industrial injury date of May 26, 1987. Review of progress notes indicates low back pain radiating to the left lower extremity, with numbness and tingling. Findings include tenderness over the lumbar region with pain upon terminal motion. There was positive seated nerve root test and dysesthesia at the L5-S1 dermatomes. X-ray of the lumbar spine dated November 26, 2013 showed disc space height collapse and spondylosis in the distal lumbar segments. Treatment to date has included chiropractic therapy, and unspecified medications. Utilization review from January 16, 2014 denied the retrospective requests (DOS 12/26/2013) for 120 naproxen 550mg as there was no documentation of failed attempts with first-line medications such as Acetaminophen; 120 Omeprazole 20mg as there was no documentation of GI complications; 120 Cyclobenzaprine 7.5mg as there were no reports of muscle spasm, and the dosage exceeds the recommended amount; 90 Tramadol as there was no documentation of failure of first-line therapy; 10 Terocin patches as there were no specific peripheral complaints; and 60 Ondansetron ODT 8mg as there was no documentation of nausea or vomiting.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO: NAPROXEN 550MG, #120; 12/26/2013: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (nonsteroidal anti-inflammatory drugs) Page(s): 67-69.

Decision rationale: As stated on pages 67-69 of the California MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and there is no evidence of long-term effectiveness for pain or function. In this case, there is no documentation whether the patient has been started on this medication. This medication is a reasonable option in the management of the patient's persistent low back pain symptoms. Therefore, the retrospective request for naproxen 550mg #120 (DOS 12/26/2013) was medically necessary.

RETRO: OMEPRAZOLE 20MG, #120; 12/26/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: According to page 68 of CA MTUS Chronic Pain Medical Treatment Guidelines, proton pump inhibitors are used in patients on NSAID therapy who are at risk for GI events. Risk factors include age > 65; history of peptic ulcer, GI bleed, or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; and high dose or multiple NSAID use. Use of PPI > 1 year has been shown to increase the risk of hip fracture. The patient has been on Prevacid since at least October 2003 and has a diagnosis of GERD. However, there is no documentation of any gastrointestinal symptoms in this patient. There is no discussion regarding discontinuation or switching from Prevacid to Omeprazole. Therefore, the retrospective request for Omeprazole 20mg #120 (DOS 12/26/2013) was not medically necessary.

RETRO: CYCLOBENZAPRINE 7.5MG, #120; 12/26/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that Cyclobenzaprine is a skeletal muscle relaxant and a CNS depressant that is recommended as a short-course therapy. The effect is greatest in the first 4 days of treatment. In this case, there is no documentation of acute exacerbations of pain or significant muscle spasms to support this request. Therefore, the retrospective request for 120 Cyclobenzaprine 7.5mg (DOS 12/26/2013) was not medically necessary.

RETRO: TRAMADOL 150MG, #90; 12/26/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-78.

Decision rationale: According to pages 76-78 of CA MTUS Chronic Pain Medical Treatment Guidelines, a therapeutic trial of opioids is recommended in cases where non-opioid analgesics have failed, goals of therapy have been set, baseline pain and functional assessments have been made, likelihood of improvement is present, and likelihood of abuse or adverse outcome is absent. In this case, there is no documentation of failure of non-opioid analgesics, goals of therapy, and baseline assessments. Therefore, the retrospective request for Tramadol 150mg #90 (DOS 12/26/2013) was not medically necessary.

RETRO: TEROGIN PATCHES, #10; 12/26/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch); Topical Analgesics, Lidocaine Page(s): 56-57; 112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Topical salicylates.

Decision rationale: Terocin Patch contains 4% Lidocaine and 4% menthol. According to CA MTUS Chronic Pain Medical Treatment Guidelines, topical Lidocaine in the formulation of a dermal patch has been designated for orphan status by the FDA for neuropathic pain. In addition, topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica). 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, Methyl Salicylate, or Capsaicin, may in rare instances cause serious burns. In this case, there is no documentation of peripheral pain, or of trial of first-line medications. Therefore, the retrospective request for Terocin Patches #10 (12/26/2013) was not medically necessary.

RETRO: ONDANSETRON 8MG, #60; 12/26/2013: 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).

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).

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and ODG was used instead. According to ODG, Ondansetron is recommended for nausea and vomiting secondary to chemotherapy, radiation, and post operative use. Acute use is FDA-approved for gastroenteritis. It is not recommended for nausea and vomiting secondary to chronic opioid use. In this case, there is no documentation of nausea and vomiting, especially that which is associated with chemotherapy, radiation, and surgery. Therefore, the retrospective request for Ondansetron ODT 8mg #60 (DOS 12/26/2013) was not medically necessary.