

Case Number:	CM14-0111787		
Date Assigned:	08/01/2014	Date of Injury:	12/02/2012
Decision Date:	09/25/2014	UR Denial Date:	06/23/2014
Priority:	Standard	Application Received:	07/17/2014

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 and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 56-year-old male was reportedly injured on 12/2/2012. The mechanism of injury was noted as a low back and right knee injury after a slip and fall. The most recent progress notes, dated 5/5/2014 and 7/3/2014, indicate that there were ongoing complaints of neck and low back pain that radiated to the right leg. Physical examination demonstrated tenderness to trapezium, which increased with axial compression of the cervical spine, restricted cervical spine range motion, hyperreflexive reflexes in upper extremities, diminished light touch sensation over C5, C6 dermatomes, motor strength 5/5 in UE right paralumbar spasm and tenderness, quadriceps atrophy, restricted lumbar spine range of motion due to pain, positive straight leg raise, reflexes absent at knees, decreased light touch sensation in the right lateral thigh, motor strength 5/5 in LE and normal gait. MRI lumbar spine, dated 4/2/2014, demonstrated 2 mm to 3 mm disk bulge and facet joint arthritis at L4-L5 and L5-S1 with modic changes and 3 mm of retrolisthesis of L5 on S1. Previous treatment included epidural steroid injection, physical therapy and medications to include tizanidine and non-steroidal anti-inflammatories. A request had been made for ondansetron 8 mg #30 x2; orphenadrine citrate 100 mg #120; tramadol 50 mg #90; terocin patch #30, which were not certified in the utilization review on 6/23/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ondansetron 8mg #30 x2: 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, Antiemetics (for opioid nausea).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): ODG-TWC - ODG Treatment, Integrated Treatment/Disability Duration Guidelines; Pain (Chronic); Antiemetic - (updated 06/10/14).

Decision rationale: Ondansetron (Zofran) is a serotonin 5-HT₃ receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy, radiation treatment, postoperatively, and acute gastroenteritis. The ODG guidelines do not recommend this medication for nausea and vomiting secondary to chronic opiate use. Review, of the available medical records, fail to document an indication for why this medication was given. As such, this request is not considered medically necessary.

Orphenadrine Citrate 100mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 65 of 127.

Decision rationale: Orphenadrine is a derivative of diphenhydramine and belongs to a family of antihistamines. It is used to treat painful muscle spasms and Parkinson's. The combination of anti-cholinergic effects and CNS penetration make it very useful for pain of all etiologies including radiculopathy, muscle pain, neuropathic pain and headaches. It is also useful as an alternative to gabapentin for those who are intolerant of the gabapentin side effects. This medication has been an abuse potential due to a reported euphoric and mood elevating effect and therefore should be used with caution as a second-line option for short-term use in both acute and chronic low back pain. Based on the clinical documentation provided, the clinician does not document any trials of first-line medications. As such, this request is not considered medically necessary.

Tramadol 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 8 C.C.R. 9792.20 -9792.26; MTUS (Effective July 18, 2009) Page(s): 93, 94 of 127.

Decision rationale: MTUS treatment guidelines support the use of tramadol (Ultram) ER for treatment of moderate to severe pain after there has been evidence of failure of a first-line option

and documentation of improvement in pain and function with the medication. Review, of the available medical records, documents a request for tramadol ER and for acute severe pain on 6/12/2014; however, the claimant has had chronic back pain since his work-related injury in December 2012. Furthermore, there is no documentation of any first-line medication trial. As such, this request is not considered medically necessary.

Terocin Patch #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 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 105, 112 of 127.

Decision rationale: Terocin is a topical analgesic containing lidocaine and menthol. MTUS guidelines support topical lidocaine as a secondary option for neuropathic pain after a trial of an antiepileptic drug or anti-depressants have failed. There is no evidence-based recommendation or support for menthol. MTUS guidelines state that topical analgesics are "largely experimental" and that "any compound product that contains at least one drug (or drug class), that is not recommended is not recommended". As such, this request is considered not medically necessary.