

<b>Case Number:</b>	CM14-0113716		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	07/14/2011
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	06/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/21/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 49 year old female who had a work related injury on 07/14/11. No clinical documentation of mechanism of injury. Most recent clinical records submitted for review were dated 06/30/14. The injured worker presented with constant pain in cervical spine aggravated by repetitive motions of the neck, pushing, pulling, lifting, forward reaching and working at or above the shoulder. Pain was characterized as dull. Pain radiated into the upper extremities. There were associated headaches that were migrainous in nature and tension between shoulder blades. Pain was improving at 4/10. The injured worker underwent surgery on 04/25/14 with C5 through C7 Anterior cervical discectomy and fusion. On physical examination the injured worker was well nourished, well developed female in no acute distress. Mood and affect were appropriate. The patient was alert and oriented to person, place, and time times three. Gait was intact. There was palpable paravertebral muscle tenderness with spasm. Spurling maneuver was negative. Range of motion was limited with pain. No clinical evidence of instability on exam. Skin is warm and dry with normal color and turgor. Sensation and strength was normal. Coordination and balance was intact. Prior utilization review on 06/25/14 there was modified to initiate tapering on to tramadol and on the orphenadrine citrate.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ondansetron 8mg, quantity (qty) 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 - Treatment in Workers Compensation, Pain Procedure Summary (Updated 05/15/2014).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter. Ondansetron (Zofran®).

**Decision rationale:** The request for Ondansetron 8mg, qty 30 is not medically necessary. The current evidence based guidelines do not support the request since Ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. It is Food and Drug Administration (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. Therefore medical necessity has not been established.

**Terocin Patch, qty 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, topical analgesics.

**Decision rationale:** The request for Terocin Patch, qty 30 is not medically necessary. The current evidence based guidelines do not support the request for Terocin patch. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Terocin patch is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no clinical documentation that the injured worker has failed trial of antidepressants and anticonvulsants. Therefore medical necessity has not been established.

**Levofloxacin 750mg, qty 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 - Treatment in Workers Compensation, Infectious Diseases Procedure Summary (Updated 02/21/2014), Mosby's Drug Consult.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Infectious disease, Levofloxacin (Levaquin®).

**Decision rationale:** The request for Levofloxacin 750mg, qty 30 is not medically necessary. The clinical documentation submitted for review does not support the request. There is no clinical

evidence of infection following the injured workers surgery of 04/25/14; therefore medical necessity has not been established.

**Orphenadrine Citrate 100mg, qty 120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain), Antispasticity Drugs, Antispasmodics, Antispasticity/Antispasmodic Drugs. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Workers Compensation, Pain Procedure Summary (Updated 05/15/2014), Muscle Relaxants, Antispasticity Drugs, Antispasmodics, Antispasticity/Antispasmodic Drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants for pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, muscle relaxants(for pain).

**Decision rationale:** The request for Orphenadrine Citrate 100mg, qty 120 is not medically necessary. Prior utilization review on 06/25/14 was modified to initiate tapering of the Orphenadrine citrate. Current evidenced-based guidelines indicate patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clinical documentation of visual analog scale with and without medication, or functional improvement. Therefore, medical necessity has not been established.

**Tramadol ER 150mg, qty 90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid's Page(s): 74-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Opioid's.

**Decision rationale:** The request for tramadol ER 150mg, qty 90 is not medically necessary. Current evidenced-based guidelines indicate patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clinical documentation of visual analog scale with and without medication, or functional improvement. Therefore, medical necessity has not been established.