

<b>Case Number:</b>	CM14-0133172		
<b>Date Assigned:</b>	08/22/2014	<b>Date of Injury:</b>	08/02/2005
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	07/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/20/2014

### 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, Pain Medicine and is licensed to practice in Texas and Ohio. 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 54-year-old male, who reported an injury of unknown mechanism on 08/02/2005. On 06/30/2014, his diagnoses included lumbago and cervicalgia. His complaints included constant pain in the cervical spine with severe dysphagia/swelling that was aggravated by repetitive motions of the neck, pushing, pulling, lifting, forward reaching, and working at or above the shoulder level. There was pain radiating to the upper extremities and migraine type headaches. He rated his cervical pain at 3/10. He also had complaints of low back pain that was rated 7/10. The treatment plan included a note stating that refills of medications were being ordered under a separate cover letter, but that cover letter was not included in the submitted documentation. There was no mention of medications in any of the clinical data, which was submitted for this worker. There was no rationale or Request for Authorization included in this worker's chart.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Omeprazole 20mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), GI symptoms & cardiovascular risk Page(s): 68-69.

**Decision rationale:** The request for Omeprazole 20mg #120 is not medically necessary. The California MTUS Guidelines suggest that proton pump inhibitors, which include omeprazole, may be recommended, but clinicians should weigh the indications for NSAIDs against GI risk factors. Factors determining if a patient is at risk for gastrointestinal events include age greater than 65 years, history of peptic ulcer, GI bleeding or perforation, concurrent use of aspirin, corticosteroids and/or an anticoagulant, or high dose/multiple NSAID use. Omeprazole is used in the treatment of dyspepsia, peptic ulcer disease, gastroesophageal reflux disease, and laryngopharyngeal reflux. The injured worker did not have any of the above diagnoses, nor did he meet any of the qualifying criteria for risks for gastrointestinal events. Additionally, the request did not specify a frequency of administration. Therefore, this request for Omeprazole 20mg #120 is not medically necessary.

**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 chapter.

**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 (for opioid nausea).

**Decision rationale:** The Official Disability Guidelines (ODG), Ondansetron is a serotonin 5HT<sub>3</sub> 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. As with other antiemetics, routine prophylaxis is not recommended for injured workers in whom there is little expectation that nausea and/or vomiting will occur postoperatively. There was no documentation submitted that this injured worker was being treated with cancer chemotherapy, full body or single dose irradiation, or that he was a candidate for surgery with a high expectation of postoperative nausea and vomiting. Additionally, the request did not specify frequency of administration. Therefore, the request for Ondansetron ODT 8mg #30 is not medically necessary.

**Menthoderm gel 120 grams:** 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): 111-113.

**Decision rationale:** The California MTUS Guidelines refer to topical analgesics as largely experimental, 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. Many agents are compounded for pain relief. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug or drug class that is not recommended, is not recommended. Methoderm gel contains methyl salicylate and menthol. Methyl salicylate has not been evaluated by the FDA for topical use in humans. Additionally, the request did not specify a body part or parts on which this gel was to have been used, nor the frequency of application. Therefore, the request for Methoderm gel 120 grams is not medically necessary.