

<b>Case Number:</b>	CM14-0133983		
<b>Date Assigned:</b>	08/25/2014	<b>Date of Injury:</b>	04/05/2013
<b>Decision Date:</b>	09/26/2014	<b>UR Denial Date:</b>	08/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2014

### 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 Florida. 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 55-year-old male who reported an injury on 04/05/2013. The mechanism of injury was not provided for clinical review. The diagnoses included lumbago and cervicalgia. The previous treatments included medication. Diagnostic testing included x-rays. Within the clinical note dated 07/10/2014 it was reported the injured worker complained of constant pain in the low back, aggravated by bending and lifting. The injured worker rated his pain 7/10 in severity. Upon the physical examination the provider noted the injured worker had palpable paravertebral muscle tenderness with spasms. A positive loading compression test was noted, including a positive Spurling's maneuver. The injured worker had limited range of motion of the cervical spine. The provider noted upon the examination of the lumbar spine the injured worker had palpable paravertebral muscle tenderness with spasms. The provider indicated the injured worker had numbness and tingling in the lateral thigh, anterior, lateral, and posterior legs, as well as foot. The request submitted is for cyclobenzaprine hydrochloride, tramadol, Menthoderm, diclofenac sodium, omeprazole, and ondansetron. However, a rationale was not provided for clinical review. The Request for Authorization was submitted and dated on 05/21/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cyclobenzaprine Hydrochloride 7.5mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Workers Compensation Pain Procedure Summary updated 6/10/14.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

**Decision rationale:** The request for Cyclobenzaprine Hydrochloride 7.5mg #120 is not medically necessary. The California MTUS Guidelines recommend nonsedating muscle relaxants with caution as a second line option for short-term treatment of acute exacerbations in patients with chronic low back pain. The guidelines note the medication is not recommended to be used for longer than 2 to 3 weeks. The injured worker has been utilizing the medication since at least 05/2014, which exceeds the guidelines' recommendation of short-term use of 4 to 12 weeks. The request submitted failed to provide the frequency of the medication. Additionally, there is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. Therefore, the request is not medically necessary.

**Tramadol ER 150mg #90:** 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, On-Going Management Page(s): 78.

**Decision rationale:** The request for Tramadol ER 150mg #90 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor control. The provider failed to document an adequate and complete pain assessment within the documentation. There is lack of documentation indicating the medication had been providing objective functional benefit and improvement. Additionally, the use of a urine drug screen was not provided for clinical review. Therefore, the request is not medically necessary.

**Menthoderm Gel 120mg #1:** 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 NSAIDs Page(s): 111-112.

**Decision rationale:** The request for Menthoderm Gel 120mg #1 is not medically necessary. The California MTUS Guidelines note topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short-term use of 4 to 12 weeks. There is lack of documentation

indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the injured worker has been utilizing the medication since at least 05/2014, which exceeds the guidelines' recommendation of short-term use. Therefore, the request is not medically necessary.

**Diclofenac Sodium ER 100mg #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 66-67.

**Decision rationale:** The request for Diclofenac Sodium ER 100mg #120 is not medically necessary. The California MTUS Guidelines recommend nonsteroidal anti-inflammatory drugs at the lowest dose for the shortest period of time. The guidelines note NSAIDs are recommended for the signs of osteoarthritis. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the injured worker has been utilizing the medication since at least 05/2014. Therefore, the request is not medically necessary.

**Omeprazole 20mg #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines GI symptoms & cardiovascular risk Page(s): 68-69.

**Decision rationale:** The request for Omeprazole 20mg #120 is not medically necessary. The California MTUS Guidelines note proton pump inhibitors such as omeprazole are recommended for injured workers at risk for gastrointestinal events and/or cardiovascular disease. The risk factors for gastrointestinal events include: over the age of 65, history of peptic ulcer, gastrointestinal bleeding or perforation, use of corticosteroids and/or anticoagulants. In the absence of risk factors for gastrointestinal bleeding events, proton pump inhibitors are not indicated when taking NSAIDs. The treatment of dyspepsia from NSAID usage includes: stopping the NSAID, switching to a different NSAID, or adding an H2 receptor antagonist or proton pump inhibitor. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, there is a lack of documentation indicating the injured worker had a diagnosis of dyspepsia secondary to NSAID therapy. Therefore, the request is not medically necessary.

**Ondansetron 8mg ODT #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 6/10/14.

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

**Decision rationale:** The request for Ondansetron 8mg ODT #30 is not medically necessary. The Official Disability Guidelines do not recommend ondansetron for nausea and vomiting secondary to chronic opioid use. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. There is a lack of clinical documentation indicating the injured worker is treated for nausea and vomiting secondary to chronic opioid use. Additionally, the request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.