

<b>Case Number:</b>	CM14-0024526		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	01/25/2013
<b>Decision Date:</b>	07/15/2014	<b>UR Denial Date:</b>	02/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/26/2014

### 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 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 44 year old male who sustained an injury on 01/25/13. No specific mechanism of injury was noted. The injured worker had been followed for ongoing complaints of both neck and low back pain with sensory loss in the 4th and 5th fingers of the right hand. Prior treatment has included the use of physical therapy with limited response. Prior electrodiagnostic studies were unremarkable for the upper extremities. The injured worker had been followed by a treating physician for upper extremity complaints. It was recommend that the injured worker undergo a right cubital tunnel release in 2013. The injured worker was also referred to another treating physician for consideration for lumbar surgery due to PARS defects at L5-S1. Medications prescribed per the clinical notes submitted included Norco. The most recent report on 02/04/14 noted ongoing tenderness to palpation and loss of lumbar and cervical range of motion as well as positive Tinel's findings in the right upper extremity as well as a positive elbow flexion test to the right. The injured worker was continued on Norco 10/325mg at this evaluation every 8 hours for pain. A urinary tox screen sample was obtained. The requested Omeprazole DR, Ondansetron, Cyclobenzaprine, Tramadol, and Terocin patches were all denied by utilization review on an undetermined date.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**OMEPRAZOLE DELAYED RELEASE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs-GI Symptoms & Cardiovascular Risk.

**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, proton pump inhibitors.

**Decision rationale:** In regards to the request for Omeprazole DR, this reviewer would not have recommended this medication as medically necessary. There is no indication from the clinical reports that this medication has been prescribed recently. The only medication noted in the clinical documentation was Norco 10/325mg. There was no provided rationale from the clinical reports regarding this medication including appropriate indications. Given the paucity of clinical information available for review to support the use of this medication, as well as the lack of any specific dose, frequency or duration; this reviewer would not have recommended the request as medically necessary.

**ONDANSETRON:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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, Anti-emetics.

**Decision rationale:** In regards to the request for Ondansetron, this reviewer would not have recommended this medication as medically necessary. There is no indication from the clinical reports that this medication has been prescribed recently. The only medication noted in the clinical reports was Norco 10/325mg. There was no provided rationale from clinical notes regarding this medication including appropriate indications. Given the paucity of clinical information available for review to support the use of this medication, as well as the lack of any specific dose, frequency or duration; this reviewer would not have recommended the request as medically necessary.

**CYCLOBENZAPRINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-67.

**Decision rationale:** In regards to the request for cyclobenzaprine, this reviewer would not have recommended this medication as medically necessary. There is no indication from the clinical reports that this medication has been prescribed recently. The only medication noted in the clinical reports was Norco 10/325mg. There was no provided rationale from clinical notes

regarding this medication including appropriate indications. Given the paucity of clinical information available for review to support the use of this medication, as well as the lack of any specific dose, frequency or duration; this reviewer would not have recommended the request as medically necessary.

**TRAMADOL HYDROCHLORIDE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 88-89.

**Decision rationale:** In regards to the request for tramadol, this reviewer would not have recommended this medication as medically necessary. There is no indication from the clinical reports that this medication has been prescribed recently. The only medication noted in the clinical reports was Norco 10/325mg. There was no provided rationale from clinical notes regarding this medication including appropriate indications. Given the paucity of clinical information available for review to support the use of this medication, as well as the lack of any specific dose, frequency or duration; this reviewer would not have recommended the request as medically necessary.

**TEROCIN PATCH:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** In regards to the request for Terocin Patches, this reviewer would not have recommended this medication as medically necessary. There is no indication from the clinical reports that this medication has been prescribed recently. The only medication noted in the clinical reports was Norco 10/325mg. There was no provided rationale from clinical notes regarding this medication including appropriate indications. Given the paucity of clinical information available for review to support the use of this medication, as well as the lack of any specific dose, frequency or duration; this reviewer would not have recommended the request as medically necessary.