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| Case Number: | CM14-0039741 | | |
| Date Assigned: | 06/27/2014 | Date of Injury: | 11/18/2013 |
| Decision Date: | 12/22/2014 | UR Denial Date: | 03/10/2014 |
| Priority: | Standard | Application Received: | 04/04/2014 |

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 California. 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:

This is a 51 year old male patient noted with an injury date of 11/18/2013 who presented for orthopedic evaluation on 12/16/2013. The injury is described as a gradual onset of pain to the neck, back, shoulders, knees, right foot and hips over the years. The patient reported symptoms to employer on multiple occasions and attempted to self-treat with over the counter medications, remedies and rest. In addition, he noted being seen for evaluation by employee physician who offered massage therapy, and electrical stimulation accompanied by cold packs. At some point over the course, he did receive orthopedic work up for which physical therapy was ordered without benefit. Physical examination noted on 12/16/2013 described paravertebral muscle spasm, positive axial loading compression test and extension of symptomology in the bilateral upper extremities. In addition, he's found with overlapping symptomology to upper extremities consistent with double crush syndrome and also has reproducible symptomology in the median nerve with a noted positive Tinel's consistent with carpal tunnel syndrome. The injured worker was diagnosed with cervical lumbar discopathy, carpal tunnel double crush syndrome, plantar fasciitis and rule out internal derangement to bilateral shoulders, bilateral hips and bilateral knees. A primary examination dated 11/04/2013 showed complaint of tinnitus for which an audiology consult was ordered. A request for services involving the following medications; Cyclobenzaprine, Terocin patch, Tramadol and Ondansetron dated 03/03/2014 and the Utilization Review denied the services on 03/10/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine Hydrochloride 7.5 mg # 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Muscle Relaxants (for pain) Page(s): 41, 42, 63, 64.

Decision rationale: Cyclobenzaprine is recommended by the MTUS Guidelines for short periods with acute exacerbations, but not for chronic or extended use. These guidelines report that the effect of cyclobenzaprine is greatest in the first four days of treatment. Cyclobenzaprine is associated with a number needed to treat of three at two weeks for symptoms improvement in low back pain and is associated with drowsiness and dizziness. Chronic use of cyclobenzaprine may cause dependence, and sudden discontinuation may result in withdrawal symptoms. Discontinuation should include a tapering dose to decrease withdrawal symptoms. This request however is not for a tapering dose. The request for Cyclobenzaprine Hydrochloride 7.5 mg # 120 is determined to not be medically necessary.

Ondansetron ODT 8 mg # 60: 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

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, Antiemetic's (for opioid nausea)

Decision rationale: The MTUS Guidelines do not address the use of Ondansetron. The ODG does not recommend the use of antiemetic's for nausea and vomiting secondary to chronic opioid use. Ondansetron is FDA approved for use with nausea as a result of chemotherapy or radiation treatments, post-operative nausea, and acutely in gastroenteritis. The request for Ondansetron ODT 8 mg # 60 is determined to not be medically necessary.

Tramadol Hydrochloride ER 150 mg # 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Weaning of Medications Page(s): 74-95,124.

Decision rationale: Tramadol is a central acting synthetic opioid that exhibits opioid activity with a mechanism of action that inhibits the reuptake of serotonin and norepinephrine with side effects similar to traditional opioids. The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare

instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. The medical reports do not provide evidence of functional improvement with the use of tramadol. There is also no evidence of significant pain reduction or improvement in quality of life with the use of tramadol. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines.

Terocin Patches # 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): 111-113.

Decision rationale: Tramadol is a central acting synthetic opioid that exhibits opioid activity with a mechanism of action that inhibits the reuptake of serotonin and norepinephrine with side effects similar to traditional opioids. The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. The medical reports do not provide evidence of functional improvement with the use of tramadol. There is also no evidence of significant pain reduction or improvement in quality of life with the use of tramadol. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines.