

Case Number:	CM14-0046642		
Date Assigned:	07/02/2014	Date of Injury:	05/14/2013
Decision Date:	09/23/2014	UR Denial Date:	04/03/2014
Priority:	Standard	Application Received:	04/14/2014

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 and Pain 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:

The injured worker is a 55-year-old male who reported an injury on 05/14/2013. The mechanism of injury was not provided. The injured worker's surgical history was stated to be none. The documentation of 10/14/2013 revealed the injured worker's medications included cyclobenzaprine, Prilosec, and Naprosyn. The injured worker was noted to undergo an MRI of the lumbar spine and x-rays. The injured worker had an EMG/NCV of the bilateral lower extremities. The documentation of 06/09/2014 revealed prior treatments included an epidural steroid injection on 12/13/2013. The injured worker was noted to have low back pain radiating down the right lower extremity that was aggravated by walking. The pain was noted to be 7/10 with medications and 8/10 without medications. The physical examination revealed the injured worker had tenderness to palpation in the spinal vertebral area at L4-S1. The injured worker had decreased range of motion due to pain. The facet signs were present in the lumbar spine. The sensory examination revealed decreased sensitivity to touch in the right lower extremity. The injured worker had negative straight leg raises. The diagnoses include lumbar disc degeneration, chronic pain, lumbar radiculitis, lumbar radiculopathy and multilevel retrolisthesis. The treatment plan was consideration of a repeat transforaminal epidural steroid injection, and the documentation indicated the injured worker's medications from another prescriber were cyclobenzaprine 7.5 mg, glucosamine hydrochloride 500 mg tablets, naproxen sodium 550 mg, ondansetron 8 mg, omeprazole DR 20 mg capsules and quazepam 15 mg tablets, as well as tramadol 50 mg tablets. There was no recent physical examination, physician note from the requesting provider, and no request for authorization provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine HCL 7.5 mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: The California MTUS Guidelines recommend muscle relaxants as a second line option for the short-term treatment of acute pain. Their use is not recommended for longer than 3 weeks. The clinical documentation submitted for review indicated the injured worker had utilized the medication since at least 10/2013. There was an insufficiency of subjective documentation to factor warrant nonadherence to guideline recommendations. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Cyclobenzaprine HCL 7.5 mg #120 is not medically necessary.

Ondansetron ODT 8 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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, Ondansetron.

Decision rationale: The Official Disability Guidelines do not recommend antiemetics for the treatment of nausea and vomiting secondary to opioid therapy. The duration of use could not be established through supplied documentation. The request as submitted failed to indicate the frequency for the requested medication, as well as the efficacy. Given the above, the request for Ondansetron ODT 8 mg #60 is not medically necessary.

Terocin Patch #30: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals, Topical Analgesic, Lidocaine Page(s): 105, 111, 112.

Decision rationale: The California MTUS guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials, to determine efficacy or safety, and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines indicate that topical lidocaine (Lidoderm)

may be recommended for localized peripheral pain, after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). No other commercially approved formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The guidelines recommend treatment with topical salicylates. Per dailymed.nlm.nih.gov, Terocin patches are topical Lidocaine and Menthol. The clinical documentation submitted for review failed to provide documentation the injured worker had a trial and failure of antidepressants and anticonvulsants. The duration of use could not be established. The request as submitted failed to indicate the frequency and strength for the requested medication. Given the above, the request for Terocin Patch #30 is not medically necessary.

Tramadol HCL ER 150 mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

Decision rationale: The California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The duration of use could not be established through supplied documentation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Tramadol HCL ER 150 mg #90 is not medically necessary.