

<b>Case Number:</b>	CM14-0047033		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	01/11/2012
<b>Decision Date:</b>	08/25/2014	<b>UR Denial Date:</b>	03/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	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 and Rehabilitation 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 66-year-old male who reported an injury on 01/22/2012. The mechanism of injury was noted to be cumulative trauma. The diagnoses were noted to be status post open reduction and internal fixation of the left distal radius; compression fracture, status post T12 kyphoplasty 03/27/2012; status post L3-S1 posterior lumbar interbody fusion; clinical left carpal tunnel syndrome; left arm, hand/wrist pain; lumbago. A clinical evaluation on 05/19/2014 noted the injured worker with increasing symptomatology and spasms in the lumbar spine as a result of the retained symptomatic lumbar spinal hardware. Physical examination of the lumbar spine revealed pain and tenderness across the iliac crest into the lumbosacral spine. There was reproducible symptomatology throughout the lumbar region over the top of what appeared to be palpable hardware. X-rays were obtained noting solid bone grafting and bone plugs that were incorporated with consolidation at the levels of L3-S1. There was osteoporosis noted. There was vertebral wedge compression fracture at the levels of T11 and T12 with cement augmentation of T12. Osteolysis was around the screws and noted in the lumbar spine at levels L3-S1. The treatment plan is for a recommendation of removing hardware in the lumbar spine at the levels of L3-S1 with inspection of fusion, possible regrafting of screw holes, and nerve root exploration if deemed necessary intraoperatively. The provider's rationale for the request was not provided within the documentation. A request for authorization for medical treatment was not submitted with this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

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

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, page(s) 64 Page(s): 64.

**Decision rationale:** The request for cyclobenzaprine hydrochloride tablets 7.5 mg quantity 120 is not medically necessary . The California MTUS Chronic Pain Medical Treatment Guidelines note cyclobenzaprine is recommended for a short course of therapy. Limited, mixed evidence does not allow for a recommendation for chronic use. Dosing is 5 mg 3 times a day. This medication is not recommended to be used for longer than 2-3 weeks. According to the guidelines, cyclobenzaprine is indicated for short term use. The recommendation for treatment is 3 weeks. The request for cyclobenzaprine is for 7.5 mg and is for a quantity of 120. The provider failed to indicate a frequency of dose; however, the guidelines recommend 5 mg 3 times a day. With a 3 week duration of therapy, it would only require 63 tablets to accomplish therapeutic effect and reassess efficacy. Therefore, the request for cyclobenzaprine hydrochloride tablets 7.5 mg quantity 120 is not medically necessary.

### **Odansetron ODT Tablets 8mg #30 X 2: 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, Ondansetron (Zofran®).

**Decision rationale:** The request for Ondansetron ODT tablets 8 mg quantity 30 x 2 is not medically necessary . The Official Disability Guidelines do not recommend Ondansetron or Zofran for nausea and vomiting secondary to chronic opioid use. Antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. They are recommended for acute use as the FDA has approved indications. Nausea and vomiting are common with the use of opioids. These side effects tend to diminish over days to weeks of continued exposure. The FDA approves antiemetics for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also approved for postoperative use and gastroenteritis. The documentation submitted for review does not indicate symptoms of nausea and vomiting. It is not noted that there is a history of gastroenteritis or a recent surgery for postoperative antiemetic therapy. In addition, the provider's request fails to indicate a frequency. Therefore, the request for Ondansetron ODT tablets 8 mg quantity 30 x 2 is not medically necessary.

### **Omeprazole Delayed-Release Capsules 20mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

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

**Decision rationale:** The request for omeprazole delayed release capsules 20 mg quantity 120 is not medically necessary . The California MTUS Chronic Pain Medical Treatment Guidelines recommend a proton pump inhibitor when an injured worker is using NSAIDs and has gastrointestinal symptoms and cardiovascular risk. The documentation provided for review does not indicate an intermediate or high risk for gastrointestinal events. Further documentation would be necessary to support a need for a proton pump inhibitor. In addition, the provider's request fails to indicate a frequency with the request. Therefore, the request for omeprazole delayed release capsules 20 mg quantity 120 is not medically necessary.

**Terocin Patch Qty 30:** 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) 111-112 Page(s): 111-112.

**Decision rationale:** The request for Terocin patch quantity 30 is not medically necessary . The California MTUS Chronic Pain Medical Treatment Guidelines indicate that topical analgesics are largely experimental in use 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. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. The guidelines also indicate topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy (tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica 75 mg). No other commercially approved topical formulation of lidocaine (whether cream, lotions, or gels) are indicated for neuropathic pain. Terocin patch is a topical analgesic containing capsaicin, lidocaine, menthol, and methyl salicylate. The injured worker's documentation does not support failure of a trial of antidepressants or anticonvulsants. Lidocaine is only recommended when provided for peripheral pain, however, not combined with any other type of commercially approved products. In addition, the provider's request fails to indicate a frequency. Therefore, the request for Terocin patch quantity 30 is not medically necessary.