

Case Number:	CM14-0055892		
Date Assigned:	09/03/2014	Date of Injury:	10/13/2012
Decision Date:	12/18/2014	UR Denial Date:	04/10/2014
Priority:	Standard	Application Received:	04/25/2014

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, has a subspecialty in Interventional Spine 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 patient is a 43-year-old male with a date of injury of 10/13/2012. According to progress report 03/13/2014, the patient presents with constant neck and low back pain. Examination revealed tenderness in the cervical spine and lumbar spine with spasm noted. Spurling's test and straight leg raise were both positive. Decreased sensory was noted at the C6 dermatome. There was decreased range of motion. The treater recommends cervical epidural injection, physical therapy, IM injection, and refill of medications. Report 04/03/2014 provides no physical examination. Request was made for naproxen sodium tablets 550 mg, cyclobenzaprine 7.5 mg, ondansetron 8 mg, omeprazole 20 mg, tramadol ER 150 mg, and Terocin patches quantity 30. The listed diagnoses are: 1. Lumbago. 2. Cervicalgia. Utilization review denied the request on 04/10/2014. There are reports 03/13/2014 and 04/03/2014 provided for review.

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 - Pain Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 64.

Decision rationale: This patient presents with chronic neck and low back pain. The treater is requesting a refill of cyclobenzaprine hydrochloride 7.5 mg #120. The treater states that this medication is prescribed for patient's muscle spasms. The MTUS Guidelines page 64 states that cyclobenzaprine is recommended for short course of therapy. Limited, mixed evidence does not allow for the recommendation for chronic use. Review of the medical file indicates the patient has been prescribed cyclobenzaprine since 05/16/2013. In this case, the patient has been prescribed muscle relaxants for long term use, which is not supported by MTUS. The request is not medically necessary.

Ondasetron ODT 8 mg #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

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, Antiemetics (for opioid nausea)

Decision rationale: This patient presents with chronic neck and low back pain. The treater is requesting ondansetron ODT tablets 8 mg #30. The MTUS and ACOEM Guidelines do not discuss Zofran; however, ODG Guidelines has the following regarding antiemetic, "Not recommended for nausea and vomiting secondary to chronic opiate use. Recommended for acute use as noted below for FDA-approved indications. Ondansetron (Zofran), this drug is a serotonin 5-HT₃ receptor antagonist. It is FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA approved for postoperative use." Treater states that this medication is prescribed for patient's nausea as a side effect utilizing cyclobenzaprine and other analgesic agents. In this case, the treater has been prescribing ondansetron on a long term basis for patient's continued nausea associated with medication use. The ODG Guidelines do not support the use of ondansetron other than for postoperative use. The request is not medically necessary.

Tramadol Hydrochloride ER 150 mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 88, 89, 76-78.

Decision rationale: This patient presents with chronic neck and low back pain. The treater is requesting a refill of tramadol hydrochloride ER 150 mg #90. The treater states this medication is prescribed for patient's acute severe pain. MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a

numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The patient has been prescribed this medication since at least 5/14/13. In the case, recommendation for further use of Tramadol cannot be supported as the treater does not provide pain assessment, outcome measure or any discussion regarding functional improvement as required by MTUS for continued opiate use. There are no urine drug screens, and aberrant issues and adverse side effects are not addressed. Given the lack of sufficient documentation for opiate management, the request is not medically necessary.

Terocin Patch #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: This patient presents with chronic neck and low back pain. The treater is requesting Terocin patch quantity 30 to "assist the patient with treatment of mild to moderate acute or chronic aches or pains." Terocin includes salicylate, capsaicin, menthol, and lidocaine. The MTUS Guidelines page 112 under lidocaine, "Indications are of neuropathic pain, recommended for localized peripheral pain after there has been evidence of trial of first-line therapy. Topical lidocaine in the formulation of a dermal patch that has been designed for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy." In this case, the patient does not present with "localized peripheral pain." The treater appears to be prescribing these patches for patient's low back and neck pain, which is not supported by the guidelines. The requested Terocin lotion is not medical necessary, and the request is not medically necessary.