MAXIMUS Federal Services

Case Number:	CM14-0064652		
Date Assigned:	07/11/2014	Date of Injury:	12/05/2011
Decision Date:	08/20/2014	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	05/07/2014

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 is licensed to practice in Texas, and Ohio. 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 12/05/2011 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to his low back and cervical spine. The injured worker's treatment history included an L4-S1 lumbar interbody fusion followed by postoperative physical therapy. The injured worker's chronic pain was managed with multiple medications to include Omeprazole, Cyclobenzaprine, Tramadol, Hydrochloride, and Terocin patches. The injured worker was evaluated on 01/16/2014. It was documented that the injured worker had low back pain radiating into the right lower extremity. Physical findings included tenderness to palpation of the lumbar spine with painful range of motion. A letter of medical necessity was provided on that date to support the use of medications. It was noted that Cyclobenzaprine had previously provided significant relief for pain and muscle spasms with this medication was being provided for a brief duration for an acute exacerbation of chronic pain. It was noted that the patient has been Naproxen which causes gastrointestinal (GI) upset, therefore requiring the use of Omeprazole as a gastrointestinal protectant. It was noted that tramadol was prescribed for an acute exacerbation of chronic pain and that the patient had previously been prescribed this medication with noted benefit. It was noted that a Terocin patch was prescribed to provide pain relief. The request for authorization was submitted on 01/16/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin patch, count 30.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111.

Decision rationale: The requested Terocin patch # 30 is not medically necessary or appropriate. This is a compounded medication that contains menthol, methyl salicylate, and capsaicin. California Medical Treatment Utilization Schedule does recommend the use of menthol and methyl salicylate in the management of osteoarthritic pain. However, the use of Capsaicin as a topical analgesic should be limited to injured workers who have failed other first line treatments. The clinical documentation submitted for review does not specifically identify that the injured worker has failed to respond to first line medications to include antidepressants or anticonvulsants. Additionally, the request as it is submitted does not clearly identify a body part or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Terocin patch # 30 is not medically necessary or appropriate.

Tramadol ER 150MG, count 90.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested Tramadol ER 150mg # 90 is not medically necessary or appropriate. The clinical documentation submitted for review indicated that this medication is being prescribed for an acute exacerbation of chronic pain. California Medical Treatment Utilization Schedule recommends that initial trials of opioids of approximately 2 weeks be provided to establish efficacy. It is also recommended that the patient undergo a urine drug screen before initiating a trial of an opioid. The clinical documentation submitted for review does not provide any evidence that the patient is monitored for aberrant behavior with urine drug screens. Additionally, the recommended amount of medication exceeds the 2 week trial recommendation. Furthermore, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Tramadol ER 150mg # 90 is not medically necessary or appropriate.

Cyclobenzaprine HCL 7.5MG, count 120.: Upheld

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

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

Decision rationale: The requested Cyclobenzaprine HCL 7.5mg # 120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends this medication for acute exacerbations or chronic pain for short durations of treatment. The clinical documentation submitted for review does indicate that the patient previously took this medication with significant benefit. However, the requested quantity exceeds the 2 to 3 week Guideline recommendation. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Cyclobenzaprine HCL 7.5mg # 120 is not medically necessary or appropriate.

Omeprazole DR 20mg # 120: Upheld

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

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

Decision rationale: The requested Omeprazole DR 20mg # 120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends ongoing use of gastrointestinal protectants is supported by documented risk factors of gastrointestinal disturbances related to medication usage. The clinical documentation does indicate that the injured worker is on a nonsteroidal anti-inflammatory drug that has a history of causing gastrointestinal upset for the patient. Therefore, a gastrointestinal protectant would be indicated in this clinical situation. However, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Omeprazole DR 20mg # 120 is not medically necessary or appropriate.

Ondansetron 8mg ODT # 30 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Treatment 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, Anti-emetics.

Decision rationale: The requested Ondansetron 8mg ODT # 30 with 1 refill is not medically necessary or appropriate. The clinical documentation submitted for review does not provide an adequate assessment of the patient's gastrointestinal system or complaints related to acute gastritis. California Medical Treatment Utilization Schedule does not address this medication. Official Disability Guidelines recommend this medication for acute gastritis. The use of

antiemetics to treat side effects related to medication usage is not recommended by Official Disability Guidelines. Without documentation of acute gastritis, continued use of this medication would not be indicated. Furthermore, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Ondansetron 8mg ODT # 30 with 1 refill is not medically necessary or appropriate.