

Case Number:	CM14-0083593		
Date Assigned:	07/23/2014	Date of Injury:	07/09/2013
Decision Date:	09/18/2014	UR Denial Date:	05/14/2014
Priority:	Standard	Application Received:	06/05/2014

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 Anesthesiology has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 34-year-old male patient with a 7/9/13 date of injury. The exact mechanism of injury has not been described. The recent medical records were hand written and partially illegible. A progress report dated on 2/20/14 indicated that the patient complained of persistent pain of the lower back that radiated to the lower extremities with numbness and tingling. Physical exam revealed tenderness at the lumbar paravertebral muscles, and pain with terminal motion. There was a positive seated nerve root test and dyesthesia at the L4-5 dermatome. He was diagnosed with Dorsolumbar discopathy with radiculitis, Left inguinal hernia, and cervical discopathy. Treatment to date: medication management. There is documentation of a previous 5/14/14 adverse determination. Omeprazole was denied, because there was no risk for upper GI side effects. Ondansetron was denied, because there was no sign of nausea. Orphenadrine citrate was modified from #120 to #30, because muscle relaxants are recommended for short-term use only. Tramadol ER was denied based on the fact that medical recorded did not indicate medical necessity of opioids. Terocin patch was denied, because there was no evidence of failure of oral medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg, #120: Upheld

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

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

Decision rationale: CA MTUS and the FDA support proton pump inhibitors in the treatment of patients with GI disorders such as gastric/duodenal ulcers, GERD, erosive esophagitis, or patients utilizing chronic NSAID therapy. However, there was documentation supporting chronic use of NSAIDs. The guidelines do recommend PPIs for patient with chronic use of NSAIDs. However, Omeprazole is recommended as once daily dosing, and this request is for 120 tablets, which would be a 4-month supply, which is excessive. Therefore, the request for Omeprazole 20mg, #120 is not medically necessary.

Ondansetron 8mg, #30: 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 FDA (Ondansetron).

Decision rationale: CA MTUS does not address this issue. The FDA states that Ondansetron is indicated for prevention of nausea and vomiting caused by cancer chemotherapy, radiation therapy, and surgery. However, there was no documentation supporting cancer therapy or postsurgical nausea. It is unclear why Ondansetron is being requested for this patient. Therefore, the request for Ondansetron 8mg, #30 is not medically necessary.

Orphenadrine Citrate, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines, state that muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement, and no additional benefit has been shown when muscle relaxants are used in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The patient presented with the pain of the lower back that radiated to the lower extremities with numbness and tingling. However, there was no description of an acute exacerbation of the patient's chronic

pain that would benefit from the short-term use of a muscle relaxant. Therefore, the request for Orphenadrine Citrate, #120 is not medically necessary.

Tramadol ER 150mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Central acting analgesics. Decision based on Non-MTUS Citation ODG(Official Disability Guidelines)/TWC(treatment in workers compensation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113.

Decision rationale: CA MTUS states that Tramadol (Ultram) is not recommended as a first-line oral analgesic. This medication has action on opiate receptors, thus criterion for opiate use per MTUS must be followed. However, there was no documentation supporting significant pain relief or functional gains following Tramadol ER use. In addition, there were no urine drug screens or documentation of lack of adverse side effects or aberrant behavior. Therefore, the request for Tramadol ER 150mg, #90 is not medically necessary.

Terocin Patch, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation <http://www.odg-twc.com/odgtwc/pain.htm#Topicalanalgesics>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

Decision rationale: MTUS chronic pain medical treatment guidelines states that topical lidocaine in the formulation of a dermal patch has been designated for orphan status by the FDA for neuropathic pain. In addition, CA MTUS states that topical lidocaine 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). However, there was no significant pain relief or functional gains reported following the use of Terocin patches. In addition, there was no evidence of failure of first line oral medication. There was no documentation provided of where the patient will use the patches, the frequency, or duration of use. Therefore, the request for Terocin Patch, #30 is not medically necessary.