

<b>Case Number:</b>	CM14-0085636		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	06/19/2012
<b>Decision Date:</b>	10/01/2014	<b>UR Denial Date:</b>	05/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2014

### 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 Family 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 patient is a 43-year-old male who has submitted a claim for lumbar disc disorder, right knee pain, and depressive disorder associated with an industrial injury date of 6/19/2012. Medical records from 2014 were reviewed. The patient complained of low back pain radiating to the right lower extremity, associated with spasm and stiffness of the lower back area. Aggravating factors included prolonged sitting, twisting, heavy lifting, prolonged walking, and exposure to cold. The patient likewise reported limited sleep at night for 4 to 5 hours secondary to pain. The symptoms were alleviated with stretching, use of a TENS unit, and medications. Physical examination showed a slight antalgic gait. The lumbar spine was positive for spasms and restricted motion. Motor strength of right ankle plantar flexors was graded 5 minus/5 and right extensor hallucis longus was graded 4/5. Sensation was diminished at right L5 dermatome. Reflexes were intact. Straight leg raise test was positive at the right. Urine drug screen from 3/17/2014 was not consistent with prescribed medications. Treatment to date has included lumbar epidural steroid injection, physical therapy, chiropractic care, acupuncture, use of a TENS unit, back brace, and medications such as Norco (since 2012), Soma (since 2012), Ibuprofen, and Zolpidem (since 2012). Utilization review from 5/19/2014 denied the request for Hydrocodone/Acetaminophen 10/325 #60 because there was no evidence of quantified functional improvement and decreased pain with medication use; denied Tizanidine 4mg #60 because there was no documented muscle spasm; modified the request for Zolpidem Tartrate 10mg #30 for the purpose of weaning because there was no documented insomnia or sleep disturbance; denied Ondansetron 4mg #10 because it was not recommended for nausea and vomiting secondary to chronic opiate use; and denied Terocin Patches 4% #30 because there was no documentation of failure of oral medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone/Acetaminophen 10/325 #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**Decision rationale:** As stated on page 78 of California MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on Norco since 2012. Urine drug screen from 3/17/2014 was not consistent with prescribed medications. Moreover, the medical records do not clearly reflect continued analgesia, continued functional benefit, or a lack of adverse side effects. MTUS Guidelines require clear and concise documentation for ongoing management. Therefore, the request for Hydrocodone/Acetaminophen 10/325 #60 is not medically necessary.

**Tizanidine 4mg #60: Upheld**

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

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

**Decision rationale:** According to page 63 of the California MTUS Chronic Pain Medical Treatment Guidelines, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In this case, patient has been on Carisoprodol since 2012. Progress report from May 2014 shifted Soma into Tizanidine without any documented rationale. Although the most recent physical examination still showed evidence of paralumbar muscle spasm, long-term use of muscle relaxant is not recommended. There is no discussion concerning need for variance from the guidelines. Therefore, the request for Tizanidine 4mg #60 is not medically necessary.

**Zolpidem Tartrate 10mg #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, Zolpidem section

**Decision rationale:** The California MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Pain Section was used instead. The Official Disability Guidelines state that Zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for short-term usually 2-6 weeks treatment of insomnia. In this case, patient has been on Ambien since 2012. Patient reported limited sleep at night for 4 to 5 hours secondary to pain. However, there was no documentation concerning sleep improvement derived from medication use. Long-term use was likewise not recommended. Furthermore, there was no discussion concerning sleep hygiene. Therefore, the request for Zolpidem Tartrate 10mg #30 is not medically necessary.

**Ondansetron 4mg #10: 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) and Ondansetron

**Decision rationale:** The California MTUS does not address Ondansetron specifically. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Pain Chapter, Antiemetics (for opioid nausea) and Ondansetron was used instead. The Official Disability Guidelines states that Ondansetron is indicated for prevention of nausea and vomiting caused by cancer chemotherapy, radiation therapy and surgery. It is not recommended for nausea and vomiting secondary to chronic opioid use. In this case, patient has no subjective complaints of nausea or vomiting. Patient is not in post-operative state. He is not receiving any chemotherapy or radiation therapy to necessitate this medication. There is no clear indication for this request. Therefore, the request for Ondansetron 4mg #10 is not medically necessary.

**Terocin Patches 4% #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 Lidocaine patch Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Section, Topical Salicylate

**Decision rationale:** Terocin patch contains both Lidocaine and Menthol. Pages 56 to 57 of California MTUS Chronic Pain Medical Treatment Guidelines state 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 anti-epilepsy drug such as Gabapentin or Lyrica). Regarding the Menthol component, California MTUS does not cite specific provisions,

but the Official Disability Guidelines Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain Menthol, Methyl Salicylate, or Capsaicin, may in rare instances cause serious burns. In this case, there was no prior use of Terocin patch. Clinical manifestations were consistent with neuropathic pain. However, there was no evidence of trial of first-line therapy. Guideline criteria were not met. Therefore, the request for Terocin Patches 4% #30 is not medically necessary.