

<b>Case Number:</b>	CM14-0086224		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	11/15/2010
<b>Decision Date:</b>	09/23/2014	<b>UR Denial Date:</b>	05/29/2014
<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 Physical Medicine and Rehabilitation and Pain Medicine, 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 39-year-old female who reported an injury on 11/15/2010. The clinical note dated 05/14/2014 indicated diagnoses of cervical discopathy, carpal tunnel syndrome/double crush syndrome, cervicgia, and right cubital tunnel syndrome/right lateral epicondylitis. The injured worker reported frequent neck, right shoulder, right elbow, right wrist, and hand. The injured worker reported her neck pain radiated to the right greater than left upper extremity associated with tingling and numbness, as well as headaches. Her right shoulder pain radiated down the arm associated with tingling and numbness. The injured worker's right wrist, hand, and finger pain was associated with tingling and numbness in her fingers. The injured worker reported her headache pain was associated with nausea and the ondansetron had been effective with treating nausea. The injured worker reported epigastric pain and stomach upset while using NSAIDs in the past for chronic pain. The injured worker reported the tramadol in the past had decreased similar acute flare-ups demonstrating improvement in function. The injured worker's prior treatments included diagnostic imaging and medication management. The injured worker's medication regimen included orphenadrine, tramadol, Terocin patch, and ondansetron. The provider submitted a request for the above medications. A request for authorization dated 05/20/2014 was submitted for orphenadrine, tramadol, Terocin patch, and ondansetron. However, a rationale was not provided for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Orphenadrine Citrate ER 100mg, #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxant Page(s): 65.

**Decision rationale:** The request for Orphenadrine Citrate ER 100mg, #120 is not medically necessary. The California Chronic Pain Medical Treatment Guidelines recommend the use of muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. It was not indicated if the injured worker had tried a first-line option for acute exacerbations. In addition, there is a lack of documentation of efficacy and functional improvement with the use of this medication. Furthermore, the request does not indicate a frequency for this medication. Additionally, the injured worker has been prescribed this medication since at least 02/2014. This exceeds the guidelines recommendation for short-term use. Therefore, the request for orphenadrine is not medically necessary.

**Tramadol Hydrochloride ER 150mg, #90:** Upheld

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

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

**Decision rationale:** The request for Tramadol Hydrochloride ER 150mg, #90 is not medically necessary. The California MTUS guidelines state tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. There is a lack of significant evidence of an objective assessment of the injured worker's pain level, functional status, and evaluation of risk for aberrant drug use behaviors and side effects. Furthermore, the request does not indicate a frequency for the tramadol. Therefore, the request for tramadol is not medically necessary.

**Terocin Patch, #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** The request for Terocin Patch, #30 is not medically necessary. The Terocin patch contains (methyl salicylate/capsaicin/menthol/lidocaine 25/0.025/10/2.5%)The California Chronic Pain Medical Treatment Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficiency or safety. Any

compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines state that Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Capsaicin is generally available as a 0.025% formulation primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain. The guidelines also indicate Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. There is a lack of evidence in the documentation to indicate the injured worker had postherpetic neuralgia, diabetic neuropathy, or postmastectomy pain to warrant the use of capsaicin. In addition, the guidelines recommend lidocaine in the form of the dermal patch Lidoderm. Therefore, lidocaine is not recommended per the guidelines. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Furthermore, the request does not indicate a frequency or dosage for the Terocin patch. Therefore, the Terocin patch is not medically necessary.

**Ondansetron ODT Tablets 8mg, #30 (2 Refills): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Procedure Summary, Antiemetics (for opioid nausea).

**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 8mg, #30 (2 Refills) is not medically necessary. The Official Disability Guidelines do not recommend Ondansetron (Zofran) for nausea and vomiting secondary to chronic opioid use. The documentation submitted did not indicate the injured worker had findings that would support she was at risk for nausea or vomiting. In addition, it was not indicated that the injured worker had findings that would support she was at risk for chemotherapy or radiation treatment. Furthermore, there is a lack of documentation of efficacy and functional improvement with the use of this medication. Additionally, the request did not indicate a frequency for the ondansetron. Therefore, the request is not medically necessary.