

Case Number:	CM14-0088321		
Date Assigned:	08/01/2014	Date of Injury:	02/25/2009
Decision Date:	12/23/2014	UR Denial Date:	05/15/2014
Priority:	Standard	Application Received:	06/12/2014

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 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:

On February 25, 2009, the injured worker suffered an injury on the job. According to the UR rationale letter, the injured worker suffers from cervical pain with spasms, and right trigger thumb, there is tenderness of the right medial elbow and left lateral epicondyle. The documentation provided was the request for medications. There was no documentation submitted to support other alternative treatments. The provider failed to submit documentation to support x-rays, Magnetic Resonance Imaging (MRI), Computed Tomography (CT) scans, or prior treatments attempted for the affected areas. Also, the documentation failed to support what affected areas were the medications being used for. On May 15, 2014 the UR denied the request for the medications, Orphenadrine citrate ER, Ondansetron, Tramadol hydrochloride ER and Terocin Patch denied as not medically necessary.

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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-64.

Decision rationale: The patient presents with cervical pain with spasms, and right trigger thumb, there is tenderness of the right medial elbow pain and left lateral epicondyle. The current request is for Orphenadrine Citrate ER 100mg #120. The treating physician states in his 04/03/2014 report for the patient to "continue prescribed medications." There was no documentation suggesting the patient had been previously prescribed the medication or for how long they had been using it. MTUS page 63 states that non-sedating muscle relaxants are recommended with cautions as second-line option for short-term treatment of acute exacerbations in patients with chronic lower back pain. MTUS page 64 lists Norflex under Antispasmodics drugs used to decrease muscle spasm in conditions such as lower back pain. The provider in this case has recommended the continuation of a muscle relaxer beyond 2-3 weeks. The current request is not supported by the MTUS guidelines. Therefore, this request is not medically necessary.

Ondansetron ODT Tablets 8 mg #30 x2, #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment for Workers Compensation (TWC), Pain.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Online Pain Chapter

Decision rationale: The patient presents with cervical pain with spasms, and right trigger thumb, there is tenderness of the right medial elbow pain and left lateral epicondyle. The current request is for Ondansetron ODT Tablets 8 mg #30 x2, #60. The MTUS and ACOEM Guidelines do not discuss Ondansetron. ODG Guidelines state, "Not recommended for nausea and vomiting secondary to chronic opioid use." The provider is requesting this medication without any documentation of nausea or stomach pain and the ODG guidelines do not recommend Ondansetron. The provider quotes a study regarding the use of Ondansetron used with opioids yet he is requesting that Ondansetron be used to counteract the effects of Cyclobenzaprine (a muscle relaxant) and other analgesics. Therefore, this request 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 Page(s): 74-96.

Decision rationale: The patient presents with cervical pain with spasms, and right trigger thumb, there is tenderness of the right medial elbow pain and left lateral epicondyle. The current request is for Tramadol Hydrochloride ER 150mg #90. The treating physician states in his 04/03/2014 report for the patient to "continue prescribed medications." MTUS recommends the usage of Tramadol for the treatment of moderate to moderately/severe pain and continued usage of the

medication must be substantiated with proper documentation of the four A's (analgesia, ADL's, Adverse effects and Adverse behavior). In this case the treating physician has not provided any of the required documentation that the MTUS guidelines require for continued opioid use. The physician states he is prescribing Tramadol for acute flare-up but is requesting a 90 day supply. He states the patient benefitted from the medication in the past in his 5/7/2014 request but does not quantify the decrease in pain or increase in function. He merely states there was an increase in function. Therefore, this 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 Page(s): 112.

Decision rationale: The patient presents with cervical pain with spasms, and right trigger thumb, there is tenderness of the right medial elbow pain and left lateral epicondyle. The treating physician requested Terocin Patch #30. The treating physician states in his 04/03/2014 report for the patient to "continue prescribed medications." Terocin is a compounded medication which includes Lidocaine, Capsaicin, Salicylates and Menthol. The MTUS guidelines p112 on topical Lidocaine states, "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)." The treating physician in this case failed to document in the reports provided any first-line therapy that the patient completed. Therefore, this request is not medically necessary.