

<b>Case Number:</b>	CM14-0092802		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	09/20/2012
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	05/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/19/2014

### 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 is licensed to practice in Nevada. 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 52-year-old male who was reportedly injured on September 20, 2012. The mechanism of injury was not listed in these records reviewed. The most recent progress note dated July 1, 2014, indicated that there were ongoing complaints of neck and low back pains. The physical examination demonstrated 6'2", 200 pound normotensive individual. There was tenderness to palpation of the cervical spine as noted with muscle spasm. A decrease in range of motion was reported. There was no noted instability identified. Motor and sensory were noted to be intact. A decrease in lumbar spine range of motion was noted along with tenderness to palpation and muscle spasm. No neurological findings were reported. Diagnostic imaging studies were not reviewed. Previous treatment included multiple medications. A request was made for multiple medications and was not certified in the pre-authorization process on May 21, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Naproxen Sodium 500 mg # 120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 66, 73.

**Decision rationale:** As noted in the MTUS Chronic Pain Guidelines, this medication is recommended as an option. However, when considering the date of injury, the injury sustained, the current treatment, and the current findings on physical examination, there is no clinical data presented to suggest any efficacy or utility with this preparation. Therefore, there is no medical necessity noted and the request is not medically necessary and appropriate.

**Omeprazole 20 mg # 120:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation NSAIDS - GI Symptoms and Cardiovascular Risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 68.

**Decision rationale:** This medication is a proton pump inhibitor useful for the treatment of gastroesophageal reflux disease (GERD) and is considered a gastric protectant for individuals utilizing non-steroidal anti-inflammatory medications. There is no indication in the record provided of a gastrointestinal disorder or complaints related to the medication. Additionally, the claimant does not have a significant risk factor for potential gastrointestinal complications as outlined by the MTUS Chronic Pain Guidelines. Therefore, the use of this medication is not medically necessary.

**Ondansetron ODT 8 mg # 30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Official Disability Guidelines, Treatment in Workers' Compensation: Antiemetic (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 chapter updated July, 2014.

**Decision rationale:** This medication is a serotonin 5-HT<sub>3</sub> receptor antagonist. It is Food and Drug Administration-approved for nausea and vomiting secondary to chemotherapy, radiation treatment, post-operatively, and acute gastroenteritis. The Official Disability Guidelines do not recommend this medication for nausea and vomiting secondary to chronic opiate use. A review of the available medical records fails to document an indication for why this medication was given. As such, this request is not considered medically necessary.

**Orphenadrine Citrate 100 mg # 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 Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 65.

**Decision rationale:** Norgesic (orphenadrine) is a derivative of diphenhydramine and belongs to a family of antihistamines. It is used to treat painful muscle spasms and Parkinson's. This medication has been an abuse potential due to a reported euphoric and mood elevating effect and therefore should be used with caution as a 2nd line option for short-term use in both acute and chronic low back pain. Based on the clinical documentation provided, the clinician does not document trials of any previous anticonvulsant medications or medications for chronic pain such as Gabapentin. Given the MTUS Chronic Pain Guidelines' recommendations that this be utilized as a 2nd line agent, the request is deemed not medically necessary.

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

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 82,113.

**Decision rationale:** This medication is a semisynthetic opioid analgesic and not recommended for first-line use. The records reflect any efficacy or utility with the utilization of this preparation. There has been no documented increase in functionality, decrease in pain, changes in symptomatology or any other parameter. Therefore, based on the clinical information presented for review and by the parameters noted in the MTUS Chronic Pain Guidelines, this request is not medically necessary.

**Sumatriptan Succinate:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Official Disability Guidelines, Treatment in Workers' Compensation: Head Procedure Summary Last Updated (3/28/14).

**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 updated July, 2014.

**Decision rationale:** This medication does have some indication for the treatment of headache; however, there is insufficient clinical data demonstrating the utility of this medication. As such, based on the clinical information presented for review and by the parameters noted in the Official Disability Guidelines, the medical necessity for this preparation has not been established.

**Terocin Patch # 30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 112.

**Decision rationale:** This is a topical preparation that includes methyl salicylate, capsaicin, menthol and lidocaine. There is no objective occasion of a neuropathic lesion. As such, this would exclude the need for a lidocaine type preparation. The MTUS Chronic Pain Guidelines notes that these medications are largely experimental," and that the inclusion of a single product is not recommended; thus, the entire preparation is not recommend. Therefore, based on the clinical information presented for review, and by the parameters noted in the MTUS Chronic Pain Guidelines, there is no medical necessity established for this topical preparation.