MAXIMUS Federal Services

Case Number:	CM14-0014794		
Date Assigned:	02/28/2014	Date of Injury:	11/20/2013
Decision Date:	03/26/2015	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/05/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 (IW) is a 36 year old female who sustained an industrial injury from continuous trauma on 11/20/2013. She has reported intermittent pain in the low back that radiates to the left buttocks. Diagnoses include lumbago. Treatment to date includes medications and conservative care. There is prior history of a low back surgery. A progress note from the treating provider dated 01/13/2014 indicates a well-healed incision over the lower spine, pain across the iliac crest into the lumbosacral spine, guarding and restriction of motion, and pain and tenderness. There is a radicular pain component that is more pronounced on the left side than the right. A treatment plan is for lumbar interbody fusion L5-S1, and preapproval for DME and postoperative medication. On 01/28/2014, Utilization Review modified a request for Cyclobenzaprine hydrochloride tablets 7.5.mg #120 to Cyclobenzaprine hydrochloride tablets 7.5.mg #20, noting the recommendation of ODS is to use this medication for no longer than two weeks. Also, there was no documentation that the claimant is experiencing muscle spasms, cramping, and trigger points. The ODG Pain Procedure Summary was cited. On 01/28/2014 Utilization Review non-certified a request for Ondansetron ODT tabs 8mg #30 times two QTY 60, noting the there was no documented support for its use. The ODG Pain Procedure Summary was cited. On 01/28/2014 Utilization Review non-certified a request for Terocin Patch QTY#10 noting there is no documentation of failed trials of first line recommendations, and documentation does not indicate the claimant is unresponsive and intolerant to all other treatments. ODG-TWC notes that any compounded product that contains at least one drug (or

drug class) that is not recommended is not recommended. Medical necessity of the requested topical compound is not established. The ODG Pain Procedure Summary was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

CYCLOBENZAPRINE HYDROCHLORIDE TABS 7.5 MG #120: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC PAIN PROCEDURE SUMMARY LAST UPDATED 01/07/2014

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

Decision rationale: The 36 year old patient presents with chronic pain in the lumbar spine, as per progress report dated 01/13/14. The request is for CYCLOBENZAPRINE HYDROCHLORIDE TABS 7.5 mg # 120. There is no RFA for this case, and the patient's date of injury is 11/20/13. The patient is status post left L5-S1 laminectomy --- date for the procedure is not mentioned---, as per progress report dated 01/13/14. The patient has been diagnosed with significant disc prolapse at L5-S1 and progressive low back pain. There is some radicular pain as well. In progress report dated 01/07/14, the patient rates the pain as 7/10, and states that it radiates left buttocks. Diagnoses, as per the same report included lumbago. The patient is working regular job duties. MTUS pg 63-66 states: "Muscle relaxants (for pain): Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP. The most commonly prescribed antispasmodic agents are carisoprodol,cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril , Amrix , Fexmid, generic available): Recommended for a short course of therapy." In this case, only two progress reports dated prior to the UR denial letter have been provided for review. In prescription dated 01/14/14, the treater states that cyclobenzaprine has been prescribed because the patient suffers from palpable muscle spasms along with sleep issues secondary to the pain. The treater also states that the patient is aware this medication should only be taken in short courses for acute spasms. It is not clear when cyclobenzaprine was prescribed for the first time. The treater does not document improvement in function or reduction in pain due to its use. Additionally, the treater's request for #120 does not indicate short-term use. Hence, the request IS NOT medically necessary.

ONDANSETRON ODT TABS 8 MG #30 TIMES TWO QUANTITY OF 60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC PAIN PROCEDURE SUMMARY LAST UPDATED 01/07/2014

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Antiemetics for opiod nausea

Decision rationale: The 36 year old patient presents with chronic pain in the lumbar spine, as per progress report dated 01/13/14. The request is for ONDANSETRON OPT TABS 8 mg # 30 TIMES QUANTITY OF 60. There is no RFA for this case, and the patient's date of injury is 11/20/13. The patient is status post left L5-S1 laminectomy --- date for the procedure is not mentioned---, as per progress report dated 01/13/14. The patient has been diagnosed with significant disc prolapse at L5-S1 and progressive low back pain. There is some radicular pain as well. In progress report dated 01/07/14, the patient rates the pain as 7/10, and states that it radiates left buttocks. Diagnoses, as per the same report included lumbago. The patient is working regular job duties. Ondansetron (Zofran) is a serotonin 5-HT3 receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use. As per ODG Guidelines, Pain (Chronic) chapter, Antiemetics (for opioid nausea), the medication is not recommended for nausea and vomiting secondary to chronic opioid use. In this case, only two progress reports dated prior to the UR denial letter have been provided for review. In prescription dated 01/14/14, the treater states that Ondansetron has been prescribed to treat nausea associated with headaches that are present with chronic cervical spine pain. It is not clear when Ondansetron was prescribed for the first time. Nonetheless, ODG guidelines recommend Ondasetron only for post-operative use and in patients suffering from nausea and vomiting secondary to chemotherapy and radiation treatment. The medication is not indicated for nausea secondary to headaches and cervical pain. Hence, the request IS NOT medically necessary.

TEROCIN PATCH QUANTITY 10: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC PAIN PROCEDURE SUMMARY LAST UPDATED 01/07/2014

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical lidocaine Page(s): 56-57, 111-113. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Lidoderm

Decision rationale: The 36 year old patient presents with chronic pain in the lumbar spine, as per progress report dated 01/13/14. The request is for TEROCIN PATCH QUANTITY 10. There is no RFA for this case, and the patient's date of injury is 11/20/13. The patient is status post left L5-S1 laminectomy --- date for the procedure is not mentioned---, as per progress report dated 01/13/14. The patient has been diagnosed with significant disc prolapse at L5-S1 and progressive low back pain. There is some radicular pain as well. In progress report dated 01/07/14, the patient rates the pain as 7/10, and states that it radiates left buttocks. Diagnoses, as per the same report included lumbago. The patient is working regular job duties. MTUS guidelines page 57 states, "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)." MTUS Page 112 also states, "Lidocaine Indication: Neuropathic pain

Recommended for localized peripheral pain." When reading ODG guidelines, chapter 'Pain (Chronic)' and topic 'Lidoderm (Lidocaine patch)', it specifies that lidoderm patches are indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." ODG further requires documentation of the area for treatment, trial of a short-term use with outcome documenting pain and function. In this case, only two progress reports dated prior to the UR denial letter have been provided for review. In prescription dated 01/14/14, the treater states that Terocin patch helps with mild to moderate acute or chronic aches or pain. Although the treater states that muscle and joint can be due to peripheral neuropathies, there is no confirmed diagnosis of neuropathic pain as required by ODG guidelines. Hence, the request IS NOT medically necessary.