

<b>Case Number:</b>	CM14-0137519		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	07/10/2013
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	07/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2014

### 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, Pain Management

### 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 49 year old male, who sustained an industrial injury on 7/10/2013. The diagnoses have included lumbago. Treatment to date has included physical therapy and medications. According to the Primary Treating Physician's Progress Report dated 7/2/2014, the injured worker complained of constant pain in the low back that was aggravated by bending, lifting, pushing, pulling, prolonged sitting or standing and walking multiple blocks. The pain was characterized as sharp with radiation into the lower extremities. Exam of the lumbar spine revealed palpable paravertebral muscle tenderness with spasm. Range of motion was guarded and restricted. Authorization was requested for medications. On 7/30/2014, Utilization Review (UR) non-certified requests for Diclofenac Sodium ER (Voltaren SR) 100mg #120, Omeprazole 20mg #120, Ondansetron ODT tablets 8mg #30 and Menthoderm Gel. UR modified requests for Cyclobenzaprine Hydrochloride tablets 7.5mg #120 to Cyclobenzaprine Hydrochloride tablets 7.5mg #20 and Tramadol Hydrochloride ER 150mg #90 to Tramadol Hydrochloride ER 150mg #60. The Medical Treatment Utilization Schedule (MTUS), American College of Occupational and Environmental Medicine (ACOEM) Guidelines and Official Disability Guidelines (ODG) were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Diclofenac Sodium ER (Voltaren SR) 100mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guideline; recommendations for NSAI.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-72.

**Decision rationale:** Regarding the request for diclofenac, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that the medication is providing any specific analgesic benefits (in terms of percent pain reduction or reduction in numeric rating scale) or any objective functional improvement. In the absence of such documentation, the currently requested diclofenac is not medically necessary.

**Omeprazole 20mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guideline; recommendations for NSAI.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

**Decision rationale:** Regarding the request for omeprazole (Prilosec), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested omeprazole (Prilosec) is not medically necessary.

**Ondansetron ODT tablets 8mg #30: 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 06/10/2014; regarding antiemetics (for opioid nausea)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain Chapter, Antiemetics

**Decision rationale:** Regarding the request for ondansetron (Zofran), California MTUS guidelines do not contain criteria regarding the use of antiemetic medication. ODG states that antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. Guidelines go on to recommend that ondansetron is approved for postoperative use, nausea and vomiting secondary to chemotherapy, and acute use for gastroenteritis. Within the

documentation available for review, there is no indication that the patient has nausea as a result of any of these diagnoses. Additionally, there are no current complaints of nausea noted. In the absence of clarity regarding those issues, the currently requested ondansetron (Zofran) is not medically necessary.

**Cyclobenzaprine Hydrochloride tablets 7.5mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment guidelines; regarding muscle relaxa.

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

**Decision rationale:** Regarding the request for cyclobenzaprine, Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the medication. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested cyclobenzaprine is not medically necessary.

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

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; criteria for a therapeu.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-80.

**Decision rationale:** Regarding the request for tramadol ER, California Pain Medical Treatment Guidelines note that it is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested tramadol ER is not medically necessary.

**Menthoderm Gel QTY: 120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; recommendations of opio.

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

**Decision rationale:** Regarding the request for Mentoderm, CA MTUS states that topical NSAIDs are indicated for Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. Given all of the above, the requested Mentoderm is not medically necessary.