

Case Number:	CM14-0023315		
Date Assigned:	05/12/2014	Date of Injury:	05/22/2013
Decision Date:	03/26/2015	UR Denial Date:	02/10/2014
Priority:	Standard	Application Received:	02/24/2014

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:

This 41 year old woman sustained an industrial injury on 5/22/2013 after he fell backwards in a physical training class. Current diagnoses includes status post left L4-L5 laminotomy and discectomy. Treatment has included oral medications, pain management referral, lumbar epidural block, physical therapy and injections. Physician notes dated 11/21/2013 show complaints of persistent pain. Recommendations include surgical intervention. No further progress notes were identified. On 2/10/2014, Utilization Review evaluated prescriptions for Cyclobenzaprine HCL 7.5 mg #120, Ondasetron 8 mg #60, Tramadol HCL 150 mg #90, and Terocin patches #30; that were submitted on 2/20/2014. The UR physician noted the following: regarding the Cyclobenzaprine, the records lack documentation of muscle spasms or acute exacerbation of back pain. Regarding Ondasetron, documentation of functional improvement was not located. Regarding Tramadol, no pain score, urine drug screening, risk assesment profile, attempt at weaning, and an updated pain contract was found. Regarding Terocin, no documentation of antidepressant and/or anticonvulsant trials were identified. The MTUS, ACOEM Guidelines (or ODG) was cited. The requests were denied and subsequently appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

CYCLOBENZAPRINE HCL 7.5MG, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS FOR PAIN.

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

Decision rationale: The patient presents with pain and weakness in his lower back and lower extremity. The request is for CYCLOBENZAPRINE HCL 7.5MG #120. MTUS guidelines page 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 exacerbations 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, the utilization review letter on 02/10/14 indicates that Cyclobenzaprine #20 were certified on 06/05/13. The treater does not indicate that this medication is to be used for a short-term and there is no documentation of any flare-up's. MTUS guidelines allow no more than 2-3 weeks of muscle relaxants to address flare up's. The request of Cyclobenzaprine #120 IS NOT medically necessary.

ONDANSETRON 8MG, #60: Upheld

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

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

Decision rationale: The patient presents with pain and weakness in his lower back and lower extremity. The request is for ONDANSETRON 8MG #60. The patient is s/p left L4-5 laminotomy and discectomy and the date of surgery is not provided. The MTUS and ACOEM guidelines do not mention Ondansetron. ODG guidelines have the following regarding antiemetics: "ODG Guidelines, Pain Chronic chapter, Antiemetics (for opioid nausea): Not recommended for nausea and vomiting secondary to chronic opioid use. Ondansetron (Zofran): This drug 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. Acute use is FDA-approved for gastroenteritis." In this case, the reports provided show no discussion as to why this medication is being prescribed. The review of report shows the patient had surgery. However, there is no indication of chemotherapy/ radiation or post-operative nausea. The patient is s/p lumbar surgery but the date is not known to show that this medication is for post-operative use. #60 prescribed appears to be for a month's supply, which is a bit excessive for post-operative use. There is no documentation regarding the patient's

gastroenteritis, either. The request does not meet guideline indications. The requested Ondansetron IS NOT medically necessary.

TRAMADOL HCL 150MG, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS- CRITERIA FOR USE.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: The patient presents with pain and weakness in his lower back and lower extremity. The request is for TRAMADOL HCL 150MG #90. Regarding chronic opiate use, MTUS guidelines page 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4A's, analgesia, ADLs, "adverse side effects, and adverse behavior", as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The review of the reports does not show any discussion specific to this medication other than the treater's request. The four A's including analgesia, ADL's, side effects, and aberrant drug seeking behavior are not addressed as required by MTUS for chronic opiate use. There are no before and after pain scales to show analgesia; no specific ADL's are mentioned to show functional improvement; no urine toxicology, CURES reports showing opiate monitoring. Given the lack of sufficient documentation demonstrating efficacy for chronic opiate use, the patient should slowly be weaned as outlined in MTUS guidelines. The request IS NOT medically necessary.

TEROCIN PATCHES #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 Topical lidocaine Topical analgesic Page(s): 56-57, 111-113. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Lidoderm patches

Decision rationale: The patient presents with pain and weakness in his lower back and lower extremity. The request is for TEROICIN PATCHES #30. None of the reports mention whether or not the patient has been utilizing this patch or its efficacy. 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, 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, the patient

presents with low back pain but no neuropathic pathology that is localized and peripheral for which this topical product is indicated per MTUS. The request IS NOT medically necessary.