

<b>Case Number:</b>	CM14-0061370		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	08/19/2013
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	04/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/02/2014

### 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 is a 41 year old male, who sustained an industrial injury on 8/19/2013. He has reported back pain. The diagnoses have included lumbar disc disease, lumbar radiculopathy, and low back pain. Treatment to date has included lumbar epidural steroid injection, 2/21/14. Documentation submitted for this review included operative notes from the epidural completed 2/21/14 and an evaluation from 11/25/13. The provider documented Magnetic Resonance Imaging (MRI) revealed L5-S1 herniated nucleus pulposus with annular tear and "some pathology at C4-5 and C5-6". The physical examination on that date of service documented cervical tenderness, muscle spasm and positive axial loading compression test and positive Spurling's maneuver. Lumbar spinal examination significant for pain and tenderness mid to distal lumbar, restricted Range of Motion (ROM), seated nerve root test was positive and radiation to right lower extremity. On 4/7/2014 Utilization Review non-certified Cyclobenzaprine HCL 7.5mg #120, Ondansetron ODT 8mg #60, Tramadol HCL 150mg #90, and Terocin Patch #10, noting the documentation did not support medical necessity per guidelines. The MTUS and ODG Guidelines were cited. On 5/2/2014, the injured worker submitted an application for IMR for review of Cyclobenzaprine HCL 7.5mg #120, Ondansetron ODT 8mg #60, Tramadol HCL 150mg #90, and Terocin Patch #10.

### 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). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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

**Decision rationale:** The patient presents with continued symptomatology in the lumbar spine. The request is for CYCLOBENZAPRINE HCL 75MG #120. The request for authorization is not available. The patient is status-post lumbar steroid epidural 02/21/14. Patient has paravertebral muscle spasm and positive Spurling's maneuver. Patient has restricted range of motion and seated nerve root test is positive. MRI of the cervical spine 10/30/13 shows 3mm anterior disc protrusion at C5-6. MRI of the lumbar spine 10/30/13 shows 3mm posterior disc protrusion/extrusion at L5-S1. The patient is on modified work duty.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."Per progress report dated 11/25/13, treater's reason for the request is "for symptomatic relief." However, MTUS only recommends short-term use (no more than 2-3 weeks) for sedating muscle relaxants. Per UR letter dated 04/07/14, patient has been prescribed Cyclobenzaprine since at least 03/31/14. The request for Cyclobenzaprine #120 would exceed MTUS recommendation and does not indicate intended short-term use. Therefore, the request IS NOT medically necessary.

**Ondansetron ODT 8mg #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)

**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 continued symptomatology in the lumbar spine. The request is for ONDANSETRON ODT 8MG #60. The request for authorization is not available. The patient is status-post lumbar steroid epidural 02/21/14. Patient has paravertebral muscle spasm and positive Spurling's maneuver. Patient has restricted range of motion and seated nerve root test is positive. MRI of the cervical spine 10/30/13 shows 3mm anterior disc protrusion at C5-6. MRI of the lumbar spine 10/30/13 shows 3mm posterior disc protrusion/extrusion at L5-S1. The patient is on modified work duty.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-HT<sub>3</sub> 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." Per progress report dated 11/25/13, treater's reason for the request is "for symptomatic relief." However, treater has not indicated that patient is postoperative, undergoing chemotherapy and radiation, or has gastroenteritis, as recommended by ODG and the FDA. Furthermore, Ondansetron is not recommended by ODG for nausea and vomiting secondary to chronic opioid use. The request does not meet guideline indications. Therefore, the request IS NOT medically necessary.

**Tramadol HCL 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 CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

**Decision rationale:** The patient presents with continued symptomatology in the lumbar spine. The request is for TRAMADOL HCL ER 150MG #90. The request for authorization is not available. The patient is status-post lumbar steroid epidural 02/21/14. Patient has paravertebral muscle spasm and positive Spurling's maneuver. Patient has restricted range of motion and seated nerve root test is positive. MRI of the cervical spine 10/30/13 shows 3mm anterior disc protrusion at C5-6. MRI of the lumbar spine 10/30/13 shows 3mm posterior disc protrusion/extrusion at L5-S1. The patient is on modified work duty. MTUS Guidelines pages 88 and 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 4As (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. Per progress report dated 11/25/13, treater's reason for the request is "for symptomatic relief." From progress report dated 11/25/14 to the UR date of 04/07/14, the patient has been prescribed Tramadol for at least 5 months. However, treater does not document or discuss how using opiates reduces pain and significantly improves patient's activities of daily living; the four A's are not specifically addressed including discussions regarding adverse effects, aberrant drug behavior and specific ADL's, etc. There are no UDS's, CURES or opioid pain contracts. Therefore, given the lack of documentation as required by MTUS, the request IS NOT medically necessary.

**Terocin patch #10:** 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 Page(s): 56-57, 111-113. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Lidoderm

**Decision rationale:** The patient presents with continued symptomatology in the lumbar spine. The request is for TEROGIN PATCH #10. The request for authorization is not available. The patient is status-post lumbar steroid epidural 02/21/14. Patient has paravertebral muscle spasm and positive Spurling's maneuver. Patient has restricted range of motion and seated nerve root test is positive. MRI of the cervical spine 10/30/13 shows 3mm anterior disc protrusion at C5-6. MRI of the lumbar spine 10/30/13 shows 3mm posterior disc protrusion/extrusion at L5-S1. The patient is on modified work duty. 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. Per progress report dated 11/25/13, treater's reason for the request is "for symptomatic relief." The patient has back pain. However, for the use of topical lidocaine patches, peripheral, localized neuropathic pain is required per guidelines. Additionally, the treater does not discuss how it is used and with what efficacy. Furthermore, the treater has not provided any documentation showing evidence of a trial of first-line therapy. Therefore, the request IS NOT medically necessary.