

Case Number:	CM14-0077428		
Date Assigned:	09/29/2014	Date of Injury:	11/14/2012
Decision Date:	11/06/2015	UR Denial Date:	04/30/2014
Priority:	Standard	Application Received:	05/27/2014

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 52 year old female, who sustained an industrial-work injury on 11-14-12. A review of the medical records indicates that the injured worker is undergoing treatment for cervicgia. Medical records dated (3-7-14 to 4-4-14) indicate that the injured worker complains of constant neck and back pain with radicular symptoms. Per the treating physician report dated 3-7-14 the injured worker has returned to work full duties. The physical exam dated from (3-7-14 to 4-4-14) reveals tenderness at the cervical spine and lumbosacral spine with spasm, positive Spurling test, positive straight leg raise, decreased range of motion and decreased sensory L5-S1. Treatment to date has included pain medication including Cyclobenzaprine, Ondansetron, Tramadol, Terocin patch at least since 4-4-14, omeprazole, left shoulder arthroscopy 12-6-13, left knee arthroscopy 4-19-13, physical therapy 24 sessions at least, and other modalities. There is no urine drug reports noted in the records. The request for authorization date was 4-4-14 and requested services included Cyclobenzaprine Hydrochloride 7.5mg, #120, Ondansetron ODT 8mg #30 x2, Tramadol Hydrochloride ER 150mg, #90 and Terocin patch #30. The original Utilization review dated 4-30-14 non-certified the request for Cyclobenzaprine Hydrochloride 7.5mg, #120 as long term use is not supported, non-certified the request for Ondansetron ODT 8mg #30 x2 as without evidence of nausea and vomiting the medical necessity is not established, non-certified the request for Tramadol Hydrochloride ER 150mg due to medication guideline non-compliance, and non-certified the request for Terocin patch #30 as there is non documentation of failed trials of anticonvulsants and anti-depressants and the medical necessity was not established.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine Hydrochloride 7.5mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment for Worker's Compensation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

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. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Given this, the current request is not medically necessary.

Ondansetron ODT 8mg #30 x2: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment for Worker's Compensation: Antiemetics (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) Chronic 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. In the absence of clarity regarding those issues, the currently requested ondansetron (Zofran) is not medically necessary.

Tramadol Hydrochloride ER 150mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: Regarding the request for Ultram (tramadol), Chronic Pain Medical Treatment Guidelines state that Ultram 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, 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 Ultram (tramadol), is not medically necessary.

Terocin patch #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding the request for Terocin, Terocin is a combination of methyl salicylate, menthol, lidocaine and capsaicin. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. Regarding the use of topical lidocaine, guidelines state that it is recommended for localized peripheral pain after there is evidence of a trial of first-line therapy. Within the documentation available for review, there is no documentation of localized peripheral pain with evidence of failure of first-line therapy as recommended by guidelines prior to the initiation of topical lidocaine. Furthermore only topical lidocaine in patch form as Lidoderm is recommended per CPMTG, and thus this component is not recommended. Therefore, the currently requested Terocin is not medically necessary.