

<b>Case Number:</b>	CM14-0088355		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	07/22/2012
<b>Decision Date:</b>	04/01/2015	<b>UR Denial Date:</b>	05/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2014

### 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 sustained an industrial injury on July 22, 2012. The injured worker complained of severe pain to the lower back and has been diagnosed with lumbago and pain in hips/pelvis. Treatment has included medications and physical therapy. Currently the injured worker complains of tenderness at the cervical spine with spasm. The treatment plan included a cervical spine epidural and medications. On May 16, 2014 Utilization Review modified orphenadrine citrate ER, tramadol hydrochloride ER 150 mg # 60 and non certified Ondansetron ODT 8 mg # 30 x 2, terocin patch # 30 citing the MTUS and Official Disability Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol Hydrochloride 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 OPIOIDSTramadol Page(s): 76-78, 88-89, 113.

**Decision rationale:** The patient presents with severe pain (not rated) in lower back with radiating symptoms into his right hip and leg. The request is for TRAMADOL HYDROCHLORIDE ER 150MG, #90. The RFA provided is dated 05/09/14. Patient's diagnosis on 04/08/14 included lumbago and pain in hips/pelvis. Patient is working full 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. MTUS p90 states, "Hydrocodone has a recommended maximum dose of 60mg/24hrs." MTUS Chronic Pain Medical Treatment Guidelines for Tramadol, page 113 for Tramadol states: Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. For more information and references, see Opioids. See also Opioids for neuropathic pain. The prescription for Tramadol was first mentioned in the progress report dated 06/18/13 and the patient has been taking the medication consistently at least since then. In this case, treater has not stated how Tramadol reduces pain and significantly improves patient's activities of daily living. There are no pain scales or validated instruments that address analgesia. The 4A's are not specifically addressed including discussions regarding adverse reactions, aberrant drug behavior, ADL's, etc. There are no discussions in relation to the UDS's, opioid pain agreement, or CURES reports, either. MTUS requires appropriate discussion of the 4A's. Given the lack of documentation as required by guidelines, the 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, Pain Procedure Summary.

**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 severe pain (not rated) in lower back with radiating symptoms into his right hip and leg. The request is for ONDANSETRON ODT 8MG #30 X2. The RFA provided is dated 05/09/14. Patient's diagnosis on 04/08/14 included lumbago and pain in hips/pelvis. Patient is working full duty. Ondansetron (Zofran) is a serotonin 5-HT<sub>3</sub> receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment, following surgery, and for acute use for gastroenteritis. 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." The prescription for Ondansetron was first mentioned in the progress report dated 02/28/13 and the patient has been taking the medication at least since then. In this case, there is no discussion of nausea and vomiting, the patient is not in a postoperative setting, and there is no indication of a prospective surgery. ODG guidelines recommend Ondansetron only for post-operative use and in patients suffering from nausea and vomiting secondary to chemotherapy and radiation treatment,

following surgery, and for acute use for gastroenteritis. The medication is not indicated for nausea secondary to chronic opioid use, headaches, and cervical pain. The patient does not present with the indication for this medication. Therefore, the request IS NOT medically necessary.

**Orphenadrine Citrate ER (Norflex) 100mg, #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66. Decision based on Non-MTUS Citation Official disability guidelines Pain (Chronic) chapter, Muscle relaxants (for pain).

**Decision rationale:** The patient presents with severe pain (not rated) in lower back with radiating symptoms into his right hip and leg. The request is for ORPHENADRINE CITRATE ER (NORFLEX) 100 MG #120. The RFA provided is dated 05/09/14. Patient's diagnosis on 04/08/14 included lumbago and pain in hips/pelvis. Patient is working full duty. For muscle relaxants for pain, MTUS Guidelines page 63 states, "Recommended non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility; however, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement." A short course of muscle relaxants may be warranted for patient's reduction of pain and muscle spasms. MTUS Guidelines do not recommend long-term use of sedating muscle relaxants and recommends using it for 3 to 4 days for acute spasm and no more than 2 to 3 weeks. ODG-TWC, Pain (Chronic) chapter, Muscle relaxants (for pain) states: ANTISPASMODICS: Orphenadrine (Norflex, Banflex, Antiflex, Mio-Rel, Orphenate, generic available): This drug is similar to diphenhydramine, but has greater anticholinergic effects. The mode of action is not clearly understood. Effects are thought to be secondary to analgesic and anticholinergic properties. This medication has been reported in case studies to be abused for euphoria and to have mood elevating effects." Per MTUS guidelines, a short course, 3 to 4 days for acute spasm and no more than 2 to 3 weeks, of muscle relaxants may be warranted for patient's reduction of pain and muscle spasms. In reviewing the provided medical reports for this case, it is not known when or if Orphenadrine was previously administered. Furthermore, the current request for quantity does not indicate intended short-term use. The request would exceed MTUS recommendation. Therefore, the request IS NOT medically necessary.

**Terocin patch, #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**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.

**Decision rationale:** The patient presents with severe pain (not rated) in lower back with radiating symptoms into his right hip and leg. The request is for TEROCIN PATCHES #30. The RFA provided is dated 05/09/14. Patient's diagnosis on 04/08/14 included lumbago and pain in hips/pelvis. Patient is working full 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, chapter 'Pain (Chronic)' and topic 'Lidoderm (Lidocaine patch)', it specifies that Terocin 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 reviewing the provided medical reports for this case, it is not known when or if Terocin patches were previously administered. Treater does not provide a reason for the request nor documents the area of treatment and impact on pain and function, as required by MTUS. Additionally, although it is acknowledged that the patient presents with pain consistent with a neuropathic etiology and that oral pain medications are insufficient in alleviating the pain symptoms, the patient does not present with localized peripheral neuropathic pain, which is a criteria, required for Terocin patch use. These patches are not indicated for low back pain. The request IS NOT medically necessary.