

<b>Case Number:</b>	CM15-0207284		
<b>Date Assigned:</b>	10/26/2015	<b>Date of Injury:</b>	09/12/2014
<b>Decision Date:</b>	12/24/2015	<b>UR Denial Date:</b>	09/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2015

### 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: New York

Certification(s)/Specialty: Anesthesiology

### 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 28 year old female, who sustained an industrial injury on 9-12-2014. The injured worker is undergoing treatment for lumbar disc herniation and lumbar facet arthropathy. Medical records dated 9-10-2015 indicate the injured worker complains of persistent neck and back pain with spasm rated 7 out of 10 and interrupting sleep. She reports occasional pain radiating to the bilateral upper extremities with numbness. The injured worker indicates medication decreases pain by 50% and lasts 2 hours. Physical exam dated 9-10-2015 notes bilateral lumbar facet loading, tenderness to palpation of the lumbar facet region and decreased lumbar range of motion (ROM). The treating physician indicates review of 3-20-2015 lumbar magnetic resonance imaging (MRI) "gives the impression degenerative disc disease (DDD) and facet arthropathy with retrolisthesis." The treating physician does not provide abnormal results of lower extremity electromyogram-nerve conduction study dated 11-3-2014. Treatment to date has included chiropractic treatment, Advil, Tylenol, Gabapentin, omeprazole, Tramadol and capsaicin cream. The original utilization review dated 9-25-2015 indicates the request for Tramadol/Acetaminophen 37.5/325mg twice a day quantity 60, Omeprazole 20mg capsules OD quantity 60, Gabapentin 600mg, half tab twice a day, quantity 30 and CM4 caps 0.05% and Cyclo 4% is non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol/Acetaminophen 37.5/325mg twice a day quantity 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, Pain, Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

**Decision rationale:** The medication requested for this patient is Ultracet (Tramadol plus Acetaminophen). According to the California MTUS, Tramadol is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. The treatment of chronic pain, with any opioid, requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. In this case, there is insufficient evidence that the opioids were prescribed according to the CA MTUS guidelines, which recommend prescribing according to function, with specific functional goals, return to work, random drug testing, an opioid contract, and documentation of a prior failure of non-opioid therapy. According to the medical documentation, there has been no indication of the medication's pain relief effectiveness and no clear documentation that the patient has responded to ongoing opioid therapy. Medical necessity for the requested medication has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested treatment with Ultracet is not medically necessary.

**Omeprazole 20mg capsules OD quantity 60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

**Decision rationale:** According to CA MTUS (2009), proton pump inhibitors, such as Omeprazole (Prilosec), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. There is no documentation indicating the patient has any GI symptoms or GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. There is no documentation of any reported GI complaints. Based on the available information provided for review, the medical necessity for Prilosec has not been established. The requested medication is not medically necessary.

**Gabapentin 600mg, half tab twice a day, quantity 30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

**Decision rationale:** According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been considered a first-line treatment for neuropathic pain. The records documented that the patient does not have neuropathic pain related to his chronic low back condition. In this case, there was no documentation of subjective or objective findings consistent with current neuropathic pain to necessitate use of Neurontin. Medical necessity for Neurontin has not been established. The requested medication is not medically necessary.

**CM4 caps 0.05% and Cyclo 4%:** Upheld

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

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

**Decision rationale:** According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the topical analgesic compound contains: Capsaicin and Cyclobenzaprine. Capsaicin is recommended only as an option in patients who have not responded to or are intolerant to other treatments and Cyclobenzaprine is not FDA approved for use as a topical application. Medical necessity for the requested topical analgesic cream has not been established. The request for the compounded topical analgesic cream is not medically necessary.