

<b>Case Number:</b>	CM15-0055830		
<b>Date Assigned:</b>	04/01/2015	<b>Date of Injury:</b>	08/08/2004
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	03/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/24/2015

### 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: California, Washington

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 44 year old female, who sustained an industrial injury on 8/8/14. The mechanism of injury was not provided. The injured worker was diagnosed as having displacement lumbar intervertebral disc without myelopathy; post laminectomy syndrome. Treatment to date has included status post lumbar fusion with instrumentation/pedicle screw placement (2010); bilateral sacroiliac joint injections (11/21/14); posterior lumbar hardware removal (4/8/14); MRI lumbar spine (9/30/12); drug screening for medical management; physical therapy; aquatic therapy; drug screening for medical management; medications. The PR-2 note dated 3/17/15 has been submitted with this request as well. The note indicates the injured worker complained of back pain and headache. The injured worker and the provider are requesting the renewal of multiple medications as medication management. The injured worker's physical examination revealed tenderness to palpation in the lumbosacral junction, 10 degree extension, 10 degree left and right lateral bending, 40 degree rotation, full range of motion of the bilateral lower extremities, 1+ deep tendon reflexes in the bilateral lower extremities, 5/5 motor strength and decreased sensation to pinprick in the dorsum of the left foot. Recommendations included continuation of the current medication regimen. There was no Request for Authorization form submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flector 1.3% Transdermal quantity 60 with one refill: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**Decision rationale:** California MTUS Guidelines state the only FDA approved topical NSAID is diclofenac, which is indicated for the relief of osteoarthritis pain. It has not been evaluated for treatment of the spine, hip or shoulder. The injured worker does not maintain a diagnosis of osteoarthritis. Topical diclofenac has not been recommended for treatment of the spine. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

**Ondansetron (Zofran), 4mg quantity 15: Upheld**

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

**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, Ondansetron, Antiemetic.

**Decision rationale:** The Official Disability Guidelines do not recommend ondansetron for treatment of nausea and vomiting secondary to chronic opioid use. It has been FDA approved for chronic nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA approved for acute gastroenteritis. The injured worker does not maintain a diagnosis of acute gastroenteritis. There is also no frequency listed in the request. As such, the request is not medically necessary.

**Belladonna-phenobarbital 16.2/0.1037/0.194mg quantity 30 with one refill: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation California MTUS/ACOEM Practice Guidelines do not specifically address the requested medication. Official Disability Guidelines do not specifically address the requested medication. Updated: 28 April 2015. U.S. National Library of Medicine. U.S. Department of Health and Human Services National Institutes of Health. Belladonna Alkaloid Combinations and Phenobarbital.

**Decision rationale:** According to the US National Library of Medicine, belladonna alkaloid combinations and phenobarbital are used to relieve cramping pain in conditions such as irritable bowel syndrome. They are also used with other medications to treat ulcers. The injured worker

does not maintain a diagnosis of irritable bowel syndrome. There is no mention of the necessity for treatment of a gastric ulcer. The medical necessity for the requested medication has not been established in this case. There is also no frequency listed in the request. As such, the request is not medically necessary.

**Diphenhydramine 25mg quantity 60 with one refill:** Upheld

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

**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, Insomnia Treatment.

**Decision rationale:** The Official Disability Guidelines state diphenhydramine is a sedating antihistamine, often utilized as an over the counter medication for insomnia treatment. The injured worker does not maintain a diagnosis of insomnia disorder. There is no indication of chronic insomnia or a chronic condition where an antihistamine may be necessary. As the medical necessity has not been established, the request cannot be determined as medically appropriate. There is also no frequency listed in the request. Given the above, the request is not medically necessary.