

Case Number:	CM14-0111781		
Date Assigned:	08/01/2014	Date of Injury:	03/11/2011
Decision Date:	10/24/2014	UR Denial Date:	06/23/2014
Priority:	Standard	Application Received:	07/17/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 53-year-old female with a date of injury of 03/11/2011. The listed diagnoses per [REDACTED] are Lumbago, and Cervicalgia. Treatment reports from 1/7/14-6/14/14 were reviewed. According to progress report 06/14/2014, the patient is status post C-spine surgery on 10/18/2013 and continues with constant pain that radiates into the upper extremities. There are associated headaches that are migrainous in nature as well as tension between the shoulder blades. The patient rates her pain as 2 on a pain scale of 1 to 10. Examination of the cervical spine revealed palpable paravertebral muscle tenderness with spasm. Range of motion is limited with pain. The medical file indicates the patient is temporarily totally disabled and not working. Physician is requesting orphenadrine citrate 100 mg #120, ondansetron 8 mg #30 with 2 refills, tramadol ER 150 mg #90, and Terocin patches #30. Utilization review denied the request on 06/23/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orphanadrine Citrate 100 mg # 120: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatemnt in Workers Compensation

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63,64.

Decision rationale: This patient is status post C-spine surgery on 10/18/2013 and continues with cervical pain that radiates into the upper extremities. The treater is requesting a refill of orphenadrine citrate 100 mg #120. The MTUS Guidelines do not recommend long-term use of muscle relaxants and recommend using it for 3 to 4 days for acute spasm and no more than 2 to 3 weeks. Review of the medical file indicates the patient has been prescribed this medication since at least 01/10/2014. In this case, this medication is not intended for long-term use, and recommendation for further refill is not recommended. Recommendation is for denial.

Ondansetron 8 mg # 30 with 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatemnt in Workers Compensation

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines: Pain (Chronic)chapter on Zofran (Ondansetron

Decision rationale: This patient is status post C-spine surgery on 10/18/2013 and continues with cervical spine pain with radiation into the upper extremities. The treater is requesting a refill of ondansetron 8 mg #30 with 2 refills for patient's nausea associated with headaches. The MTUS and ACOEM Guidelines do not discuss Zofran; however, ODG Guidelines has the following regarding antiemetic, "Not recommended for nausea and vomiting secondary to chronic opiate use. Recommended for acute use as noted below for FDA-approved indications. Ondansetron (Zofran), this drug is a serotonin 5-HT₃ receptor antagonist. It is FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA approved for postoperative use." In this case, the treater has been prescribing ondansetron on a long-term basis for patient's continued nausea associated with headaches. The ODG Guidelines do not support the use of ondansetron other than for postoperative use. Recommendation is for denial.

Tramadol ER 150 mg # 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS (MTUS,CRITERIA FOR USE OF OPIOIDS Page(s): 88,89,76-78.

Decision rationale: This patient is status post C-spine surgery on 10/18/2013 and continues with cervical spine pain that radiates into the upper extremity. The treater is requesting a refill of tramadol ER 150 mg #90. MTUS Guidelines pages 88 and 89 state, "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. Progress report from 05/06/2014 states the patient needs refills and notes medications are "helping." There is no other discussion regarding medication efficacy or functional improvement to warrant long-term use of Tramadol. The treater does not provide a pain scale for documentation of pain assessment, or outcome measures as required by MTUS. Furthermore, there is no urine drug screen provided to monitor medications or discussion of a possible aberrant behaviors or side effects. Given the lack of sufficient documentation for opioid management, recommendation is for denial.

Terocin Patch # 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines The MTUS has the following regarding topical creams,chronic pain section):Topical Analgesic.

Decision rationale: This patient is status post C-spine surgery on 10/18/2013 with continued cervical spine pain that radiates into the upper extremities. The treater is requesting a refill of Terocin patches #30. The MTUS Guidelines page 112 states under lidocaine, "Indications are for neuropathic pain, recommend for localized peripheral pain after there has been evidence of trial of first line therapy." The medical records indicate the patient has been prescribed Terocin patches since 01/10/2014. In this case, the patient does not present with "localized peripheral pain." The treater appears to be prescribing the patches for patient's chronic neck pain which is not supported by MTUS. Recommendation is for denial.