

<b>Case Number:</b>	CM14-0123383		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	09/23/2012
<b>Decision Date:</b>	10/23/2014	<b>UR Denial Date:</b>	07/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/05/2014

### 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 Anesthesiology and Pain Medicine, and is licensed to practice in Florida. 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 injured worker is a 55-year-old male, who reported an injury on 09/23/2012. The mechanism of injury involved heavy lifting. The current diagnosis is lumbago. The injured worker was evaluated on 07/30/2014 with complaints of constant lower back pain. The injured worker also reported radiation into the bilateral lower extremities and activity limitation. It is noted that the injured worker underwent a lumbar interbody fusion in 02/2013. Previous conservative treatment is also noted to include medication management, physical therapy, activity modification, and lumbar epidural steroid injection. Physical examination revealed a well healed incision, mild cellulitis and erythema around the surgical site, and intact sensation in the lower extremities. Flexion and extension view radiographs of the lumbar spine revealed spondylosis and solid fusion at L3-5. Treatment recommendations at that time included continuation of the current medication regimen. A Request for Authorization form was submitted on 07/14/2014 for diclofenac sodium ER 100 mg, omeprazole 20 mg, ondansetron 8 mg, cyclobenzaprine 7.5 mg, and tramadol ER 150 mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Naproxen 550 mg. #100:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs (NSAIDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

**Decision rationale:** The California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. There is no documentation of an acute exacerbation of chronic pain. The injured worker has continuously utilized this medication for an unknown duration without evidence of objective functional improvement. Guidelines do not recommend long term use of NSAIDs. There is no frequency listed in the current request. As such, the request is not medically appropriate.

**Ondansetron 8 mg. #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 (ODG) - Treatment in Workman's Compensation (TWC): Pain Procedure Summary, 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, Ondansetron, Antiemetic.

**Decision rationale:** The Official Disability Guidelines state ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. Ondansetron is recommended for nausea and vomiting secondary to chemotherapy and radiation treatment. Therefore, the medical necessity for the requested medication has not been established. There is also no frequency listed in the request. As such, the request is not medically appropriate.

**Omeprazole 20mg. #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs (NSAIDs),Gastrointestinal.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69..

**Decision rationale:** The California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the medical necessity for the requested medication has not been established. There is also no frequency listed in the request. As such, the request is not medically appropriate.

**Tramadol 150 mg. #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82..

**Decision rationale:** The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized this medication for an unknown duration. There is no documentation of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically appropriate.

**Terocin Patch #30:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation of a failure to respond to first line oral medication. There is also no strength or frequency listed in the current request. As such, the request is not medically appropriate.

**Orphenadrine 100 mg. #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain); Antispasticity/Antispasmodics Drugs. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -Treatment in Workman's Compensation (TWC): Pain Procedure Summary, Muscle Relaxants (for pain), Antispasticity/Antispasmodics Drugs

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66..

**Decision rationale:** The California MTUS Guidelines state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations. There was no documentation of palpable muscle spasm or spasticity upon physical examination. There was also no documentation of this injured worker's current utilization of this medication. There is no frequency listed in the request. As such, the request is not medically appropriate.

