

Case Number:	CM14-0029475		
Date Assigned:	06/20/2014	Date of Injury:	09/12/2009
Decision Date:	09/16/2014	UR Denial Date:	02/07/2014
Priority:	Standard	Application Received:	03/07/2014

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, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 40-year-old male who has submitted a claim for left shoulder impingement syndrome, compound fracture of right femur, status post IM rodding right femur with retained symptomatic hardware, right distal locking screws; associated with an industrial injury date of September 12, 2009. Medical records from 2013 to 2014 were reviewed. The patient complained of pain in the right hip, thigh and knee with associated instability. There is also constant pain in the left shoulder that radiates to the upper extremity. Patient also complains of pain in the cervical spine. Physical examination of the right lower extremity reveals well-healed incisions and scars noted with bone grafting and IM rodding of the right femur. The patient does have pain in the superior patella region possibly consistent with retained symptomatic hardware and distal locking screws of the IM rod. There appears to be some dysesthesia and radiculopathy from the lumbar spine. Examination of the left shoulder reveals tenderness around the anterior glenohumeral region and subacromial space with a positive Hawkins' impingement sign. There is also noted decrease in range of motion. Treatment to date has included medications and surgery. Utilization review from February 7, 2014 denied the requests for Ondansetron ODT tablets 8mg #30x2 QTY 60 because there was no documentation that the patient experienced nausea and vomiting from previous medication regimen. The same review denied the request for Tramadol Hydrochloride ER 150mg #90 because the records failed to present clear documentation to meet the criteria mentioned in the guidelines. The request for Terocin patch #10 was denied because there is little evidence to utilize topical NSAIDs for this case.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ondansetron ODT tablets 8mg #30x2 QTY 60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation X Other Medical Treatment Guideline or Medical Evidence: FDA, Ondansetron.

Decision rationale: The California MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, FDA was used instead. The FDA states that Ondansetron is indicated for prevention of nausea and vomiting caused by cancer chemotherapy, radiation therapy and surgery. In this case, there is no evidence in the documentation submitted of any episodes of nausea or vomiting from previous medication regimen, radiation therapy or surgery. The patient complained of nausea associated with the headaches present with chronic cervical pain. However, there is no documentation that the patient failed other first line agents in the management of his nausea. The medical necessity has not been established. Therefore, the request for Ondansetron ODT tablets 8mg #30x2 QTY 60 is not medically necessary.

Tramadol Hydrochloride ER 150mg #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 93-94, 113.

Decision rationale: According to page 93-94 and 113 of the California MTUS Chronic Pain Medical Treatment Guidelines, Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. Tramadol is indicated for moderate to severe pain. In addition, guidelines do not support ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In this case, patient has been taking Tramadol since at least January 2014 (8 months to date). There was no documented evidence of pain relief and functional improvement from the medication. In addition, specific measures of analgesia and improvements in activities of daily living were not documented. There was also no documentation of adverse effects. Urinary drug screening was not documented. MTUS Guidelines require clear and concise documentation for ongoing management. Medical necessity has not been established. Therefore, the request for Tramadol Hydrochloride ER 150mg #90 is not medically necessary.

Terocin patch #10: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm, Topical Analgesics, Lidocaine Page(s): 56-57, 112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter, Topical salicylates.

Decision rationale: Terocin Patch contains 4% Lidocaine and 4% menthol. According to CA MTUS Chronic Pain Medical Treatment Guidelines, topical Lidocaine in the formulation of a dermal patch has been designated for orphan status by the FDA for neuropathic pain. In addition, 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). Regarding the Menthol component, CA MTUS does not cite specific provisions, but the ODG Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, methyl salicylate, or capsaicin, may in rare instances cause serious burns. In this case, patient has been prescribed usage of Terocin patch since at least January 2014 (8 months to date). It was being prescribed to assist the patient with treatment of mild to moderate acute or chronic aches or pain. However, there was no documented evidence of functional improvement from the medication. Furthermore, there was no indication of a trial of antidepressants or AED and intolerance to oral analgesics. Therefore, the request for Terocin patch #10 is not medically necessary.