

Case Number:	CM13-0024200		
Date Assigned:	03/14/2014	Date of Injury:	03/25/2013
Decision Date:	05/29/2014	UR Denial Date:	09/10/2013
Priority:	Standard	Application Received:	09/13/2013

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 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 an employee of [REDACTED] and has submitted a claim for cervicalgia associated with an industrial injury date of March 25, 2013. A utilization review from September 10, 2013 denied the requests for Cyclobenzaprine, Quazepam, Tramadol, Cidaflex, Sumatriptan, Ondansetron, Medrox, Lenza Gel, Ketoprofen, Norco, Levofloxacin, and Alprazolam due to lack of objective findings to support their use. Treatment to date has included physical therapy, home exercise program, and opioid and non-opioid pain medications. Medical records from 2013 reflected that the patient complained of neck pain that radiates to the upper extremities with numbness and tingling. There are also associated chronic headaches and migraines. Physical exam demonstrated tenderness over the cervical spine. Spurling's test and axial loading compression test were both positive. There is also painful and restricted range of motion. It is noted to be dysesthesia at the C5-C6 dermatomes. The bilateral shoulders demonstrated tenderness anteriorly with positive impingement sign and Hawkins' sign. Range of motion was limited and painful for the shoulders.

IMR ISSUES, DECISIONS AND RATIONALES

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

CYCLOBENZAPRIN HYDROCHLORIDE TABLETS 7.5MG #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41-42.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines, state that cyclobenzaprine is recommended as an option as a short course therapy for management of back pain. In this case, the patient had been using this medication since April 2013; long-term use is not recommended. There is no discussion concerning the need for variance from the guidelines. Therefore, the request for Cyclobenzaprine Hydrochloride tablets 7.5 mg # 120 is not medically necessary and appropriate.

QUAZEPAM 15MG CIV QUANTITY 30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation nlm.nih.gov

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 2009 Page(s): 24.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because of unproven long-term efficacy and risk of dependence; use is limited to 4 weeks. The patient has been prescribed this medication in August 2013. However, there is no documentation concerning the treatment plan for this medication; no indication of short term use. The request for Quazepam 15 MG CIV, quantity 30 is not medically necessary and appropriate.

TRAMADOL HYDROCHLORIDE ER 150 MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that ongoing opioid treatment should include monitoring of analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors; these outcomes over time should affect the therapeutic decisions for continuation. In this case, the patient has been taking this medication since April 2013. However, there is no documentation concerning objective pain relief or functional improvement from the use of this medication. The request for Tramadol Hydrochloride ER 150 mg, # 90 is not medically necessary and appropriate.

CIDAFLEX TABLETS #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 (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines, state that Glucosamine and Chondroitin Sulfate are recommended as an option given its low risk for patient with moderate arthritis pain especially for knee osteoarthritis. In this case, the patient was prescribed this medication in August 2013. However, there was no documentation about moderate arthritic pain for this patient. The request for Cidaflex tablets # 120 is not medically necessary and appropriate.

SUMATRIPTAN SUCCINATE TABLETS 25MG, #9, 2 REFILLS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation nlm.nih.gov.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physician's Desk Reference 2014, Sumatriptan.

Decision rationale: The California MTUS does not address sumatriptan specifically. The Physician's Desk Reference 2014 state that Sumatriptan is used for the acute treatment of migraine attacks with or without aura in adults. In this case, the patient was first prescribed Sumatriptan in August 2013. Although the patient did complain of migraines, the outcome from the use of Sumatriptan was not clearly documented. The request for Sumatriptan Succinate tablets 25 mg# 90, two refills is not medically necessary and appropriate.

ONDANSETRON ODT TABLETS 4MG #30 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 (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Antiemetics (For Opioid Nausea) and Ondansetron.

Decision rationale: The California MTUS does not address Ondansetron specifically. The Official Disability Guidelines (ODG) states that Ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. In this case, the patient was prescribed Ondansetron since April 2013. There has been no documentation concerning complaints of nausea and vomiting in the progress notes reviewed. The request for Ondansetron ODT tablets 4 mg, #30, two refills is not medically necessary and appropriate.

MEDROX PATCH QUANTITY 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 2009
Page(s): 111-113.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. Medrox contains Methyl salicylate/capsaicin 0.0375%/Menthol. The California MTUS states that there are no current indications for a capsaicin formulation of 0.0375%. The Official Disability Guidelines (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. The guidelines do not address Camphor however, any compounded product that contains at least one drug (drug class) that is not recommended is not recommended. In this case, the patient has been using Medrox since April 2013. However, there were no discussions concerning the need for variance from the guidelines. The request for Medrox patch, quantity 30 is not medically necessary and appropriate.

LENZA GEL 120GRAM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 2009
Page(s): 111-113.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. Lenza Gel contains Lidocaine 4% and Menthol. The California MTUS only supports lidocaine topical as a patch formulation. The Official Disability Guidelines (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. Any compounded product that contains at least one drug (drug class) that is not recommended is not recommended. In this case, the patient was prescribed this medication in August 2013. However, there was no discussion concerning the need for variance from the guidelines. The request for Lenza Gel 120 gm is not medically necessary and appropriate.

KETOPROFEN CAPSULES 75MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 2009
Page(s): 67-68.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs are useful in treating breakthrough and mixed pain conditions such as neuropathic pain, osteoarthritis, and back pain; there is no evidence for long-term effectiveness for pain and

function. In this case, the patient has been prescribed this medication since August 2013. The outcomes of use were not clearly documented; functional improvements attributed to the use of this medication were not indicated. The request for Ketoprofen capsules 75 mg is not medically necessary and appropriate.

HYDROCODONE/ACETAMINOPHEN NORCO TABLET 10MG-325MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that ongoing opioid treatment should include monitoring of analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors; these outcomes over time should affect the therapeutic decisions for continuation. In this case, the patient has been prescribed this medication since August 2013. The outcomes of use were not clearly documented; functional improvements and pain relief attributed to the use of this medication were not indicated. The request for Hydrocodone/Acetaminophen Norco tablet 10mg-325mg, is not medically necessary and appropriate.

LEVOFLOXACIN 750MG 750MG #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation nlm.nih.gov

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physician's Desk Reference 2014, Levofloxacin.

Decision rationale: The California MTUS does not address sumatriptan specifically. The Physician's Desk Reference 2014 state that Levofloxacin is an antibiotic used to treat a variety of infections. In this case, the patient was prescribed Levofloxacin in August 2013. However, there was no evidence in the documentation that the patient had an ongoing infection. The request for Levofloxacin 750mg, # 30 is not medically necessary and appropriate.

ALPRAZOLAM EXTENDED RELEASE TABLETS 1MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because of unproven long-term efficacy

and risk of dependence; use is limited to 4 weeks. The patient was prescribed this medication in August 2013. However, there is no documentation concerning the treatment plan for this medication; no indication of short term use. The request for Alprazolam extended release tablets 1mg is not medically necessary and appropriate.