

<b>Case Number:</b>	CM13-0027929		
<b>Date Assigned:</b>	11/22/2013	<b>Date of Injury:</b>	04/09/2013
<b>Decision Date:</b>	01/22/2014	<b>UR Denial Date:</b>	09/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine, has a subspecialty in Pulmonary Diseases 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 physician 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 38-year-old male who reported an injury on 04/09/2013. The patient is currently diagnosed with cervical and lumbar discopathy, lumbar segmental instability, and rule out double crush syndrome. The patient was recently seen by [REDACTED] on 10/10/2013. The patient reported continued symptomatology in the lumbar spine with extension into the right lower extremity. Physical examination revealed no significant changes, increasing range of motion of the cervical spine without any radicular pain component, tenderness from the mid-to-distal lumbar segments, right sciatic notch, gluteal area and right hip anterolateral aspect, pain with terminal motion, positive straight leg raising, and dysesthesia at the right L5 and S1 dermatomes. Treatment recommendations included continuation of current medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Medrox patch #30 for DOS 8/13/2013: 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 Page(s): 111-113.

**Decision rationale:** The Physician Reviewer's decision rationale: Medrox ointment and patch is a topical medication containing methyl salicylate, capsaicin, and menthol. California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. It is indicated for fibromyalgia, osteoarthritis, and chronic nonspecific back pain. Additionally, despite the ongoing use of this medication, the patient continues to report persistent chronic pain. Satisfactory response to treatment has not been indicated. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.

**Retrospective Tramadol ER 150mg #90 for DOS 8/13/2013: 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 Page(s): 74-82.

**Decision rationale:** The Physician Reviewer's decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. Despite the ongoing use of this medication, the patient continues to report persistent pain. There have been no changes to the patient's physical examination that would indicate functional improvement. There is also no evidence of a failure to respond to nonopioid analgesics prior to the initiation of an opioid. Satisfactory response to treatment has not been indicated by a decrease in pain, increase in activity, or improved quality of life. Ongoing use of this medication cannot be determined as medically appropriate. As such, the request is non-certified.

**Retrospective Cyclobenzaprine 7.5mg #120 for DOS 8/13/2013: 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 Page(s): 63-66.

**Decision rationale:** The Physician Reviewer's decision rationale: California MTUS Guidelines state muscle relaxants are recommended as non-sedating second-line opioids for short-term treatment of acute exacerbations in patients with chronic low back pain. However, in most lower back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. Cyclobenzaprine is recommended for a short course of therapy, and should not be used for longer than 2 to 3 weeks. Despite the ongoing use of this medication, the patient continues to

report persistent pain. There is no evidence of palpable muscle spasm or muscle tension upon physical examination. As guidelines do not recommend chronic use of this medication, the current request cannot be determined as medically appropriate. As such, the request is non-certified.

**Retrospective Ondansetron ODT 8mg #60 for DOS 8/13/2013: 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 Official Disability Guidelines (ODG) Chronic Pain Chapter, Ondansetron, Anti-emetics.

**Decision rationale:** The Physician Reviewer's decision rationale: Official Disability Guidelines state Zofran is not recommended for nausea and vomiting secondary to chronic opioid use. Anti-emetics are not recommended. Nausea and vomiting is common with the use of opioids and these side effects tend to diminish over days to weeks of continued expose. Zofran is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation, and has also been approved for postoperative use. As per the clinical notes submitted, the patient does not currently meet criteria as outlined by Official Disability Guidelines for the use of this medication. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.

**Retrospective Omeprazole DR 20mg #120 for DOS 8/13/2013: 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 Page(s): 68-69.

**Decision rationale:** The Physician Reviewer's decision rationale: 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. As per the clinical notes submitted, the patient does not currently meet criteria for the use of a proton pump inhibitor. There is no evidence of cardiovascular disease or risk factors for gastrointestinal events. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.

**Retrospective Naproxen 550mg #100 for DOS 8/13/2013: 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 Page(s): 67-72.

**Decision rationale:** The Physician Reviewer's decision rationale: California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain. There is no evidence to recommend 1 drug in this class over another based on efficacy. Despite the ongoing use of this medication, the patient continues to report persistent pain. The patient does not maintain a diagnosis of osteoarthritis. As guidelines do not recommend the chronic use of this medication, the current request cannot be determined as medically appropriate. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.