

<b>Case Number:</b>	CM13-0028306		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	01/01/1997
<b>Decision Date:</b>	01/30/2014	<b>UR Denial Date:</b>	09/19/2013
<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 Cardiology and is licensed to practice in Texas. 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 43-year-old male who reported an injury on 12/06/2012. The mechanism of injury was not provided for review. The patient reportedly sustained an injury to the cervical spine that resulted in chronic headaches and injury to the thoracolumbar spine, right shoulder, right elbow, and bilateral knees. The patient's chronic pain was treated with medication usage. The patient's most recent examination findings included well-healed incision with no significant neurological deficit, tenderness to the medial and lateral epicondyle of the left elbow with a positive Tinel's sign, and pain with terminal flexion. The patient's diagnoses included status post bilateral carpal tunnel release, status post right cubital tunnel release, right lateral epicondylar release, left cubital tunnel syndrome, and triangular fibrocartilage disc tear of the right wrist. The patient's treatment plan was to continue medications for pain control.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Cyclobenzaprine 7.5 #120 for DOS 9/10/2013: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (flexeril, Amrix, Fexmid, generic available)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 64.

**Decision rationale:** The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration. However, the clinical documentation submitted for review from 09/10/2013 did indicate the patient had prior functional benefit and symptom relief as result of this medication. However, California Medical Treatment Utilization Schedule recommends the short-term use of cyclobenzaprine. California Medical Treatment Utilization Schedule recommends up to 4 weeks as appropriate duration for this medication. The request is for 120 tablets. This would exceed guideline recommendations of 4 weeks. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested cyclobenzaprine 7.5 #120 for date of service 09/10/2013 is not medically necessary or appropriate.

**Retrospective Ondansetron 8mg #60 for DOS 9/10/2013: 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), Pain (Chronic), Ondansetron (Zofran).

**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).

**Decision rationale:** The retrospective request for ondansetron 8 mg #60 for date of service 09/10/2013 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has gastric upset related to medication usage. Official Disability Guidelines do not recommend antiemetics for the use of nausea and vomiting related to medication usage. This medication is indicated according to guideline recommendations for postsurgical nausea and vomiting and cancer treatment related nausea and vomiting. It is also recommended for acute instances of gastroenteritis. The clinical documentation submitted for review for 09/10/2013 does not provide any evidence the patient is receiving cancer treatment, has an acute case of gastroenteritis, or has postsurgically induced nausea and vomiting. As such, the requested ondansetron 8 mg #60 for date of service 09/10/2013 is not medically necessary or appropriate.

**Retrospective Medrox patch #30 for DOS 9/10/2013: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and Topical Analgesics Page(s): 60 & 111-113.

**Decision rationale:** The retrospective request for the Medrox patch #30 for date of service 09/10/2013 is not medically necessary or appropriate. The clinical documentation submitted for review on 09/10/2013 does not provide physical evidence of deficits that would require medication management. This formulation of Medrox patches includes methyl salicylate,

menthol, and capsaicin. California Medical Treatment Utilization Schedule does recommend the use of methyl salicylate and menthol in the treatment of osteoarthritic pain. The clinical documentation submitted for review does not provide any evidence that the patient's pain is related to osteoarthritis. Additionally, this formulation contains capsaicin. California Medical Treatment Utilization Schedule does not recommend capsaicin as a topical agent unless the patient has failed to respond to other first-line treatments and oral analgesics. There was no evidence within the documentation on 09/10/2013 that the patient has failed to respond to first-line treatments or oral analgesics. As such, the requested Medrox patch #30 for date of service 09/10/2013 is not medically necessary or appropriate.

**Retrospective Tramadol Hydrochloride ER 150mg #90 for DOS 9/10/2013: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** The retrospective request for tramadol hydrochloride extended release 150 mg #90 for date of service 09/10/2013 is not medically necessary or appropriate. The clinical documentation for 09/10/2013 does not provide any deficits that would require medication management. Additionally, California Medical Treatment Utilization Schedule recommends continued use of opioids be based on significant functional benefit, assessment of pain relief, assessment of side effects, and documentation of monitoring for aberrant behavior. The clinical documentation submitted for review for 09/10/2013 does not provide any evidence of significant pain relief, significant functional benefit, and assessment of side effects or monitoring for aberrant behavior. As such, the requested tramadol hydrochloride extended release 150 mg #90 for date of service 09/10/2013 is not medically necessary or appropriate.