MAXIMUS Federal Services

Case Number:	CM13-0038390		
Date Assigned:	12/18/2013	Date of Injury:	12/08/2006
Decision Date:	02/19/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	10/25/2013

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 Physical Medicine and Rehabilitation and is licensed to practice in Ohio and 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 57-year-old female who reported an injury on 12/08/2006. The mechanism of injury was continuous trauma related to the performance of job duties. The patient complained of injuries to her neck and right shoulder, right hand, right-sided headache, left ankle pain, upper and mid back pain, and low back pain with radiation into the bilateral lower extremities. She received several imaging studies of the spine, unspecified injections, physical therapy, and an EMG/NCV to the bilateral upper extremities and bilateral lower extremities; however, these results were not included for review. The patient underwent a right shoulder suprascapular nerve injection on 06/23/2011; however, there is no discussion regarding the results. The patient was subsequently diagnosed with right carpal tunnel syndrome, cervical discopathy with radiculitis, lumbar discopathy, right shoulder impingement syndrome, bilateral epicondylitis, left carpal tunnel syndrome, and right De Quervain's syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medrox Patch #30, (DOS: 8-27-13): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

Decision rationale: The California MTUS/ACOEM Guidelines recommend the use of topical analgesics to treat neuropathic and osteoarthritic pain. The Guidelines also state that if any compounded product contains at least one drug that is not recommended, the entire product is not recommended. Medrox contains a mixture of menthol 5% and capsaicin 0.0375%. The Guideline recommendations currently do not approve the use of capsaicin in excess of a 0.025% formulation as there is no evidence that an increased dose is beneficial. As such, the current request for Medrox patch, #30 (DOS:8-27-13) is non-certified.

Ondansetron 4 or 8mg #60 (DOS: 8-27-13): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Pain Chapter

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

Decision rationale: The California MTUS/ACOEM Guidelines do not specifically address the use of ondansetron; therefore, the Official Disability Guidelines were supplemented. The Official Disability Guidelines do not recommend antiemetics to control nausea and vomiting secondary to chronic opioid use. Ondansetron in particular, is approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also approved for immediate postoperative use and acute gastroenteritis. Although the patient had undergone recent carpal tunnel release, the prescription was provided over a week postoperatively. There were no other indications present to support the medication's use, nor were there directions for frequency provided in the notes or the request. As such, the request for ondansetron 4 or 8 mg #60 (DOS: 08/27/2013) is non-certified.

Cyclobenzaprine Hydrochloride Tablets 7.5mg #120 (DOS: 8-27-13): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-64.

Decision rationale: The California MTUS/ACOEM Guidelines recommend non-sedating muscle relaxants as a second-line option for the short-term treatment of acute exacerbations of lower back pain. Cyclobenzaprine in particular, is an antispasmodic used to decrease muscle spasms; however, its use is not recommended for longer than 3 weeks. The medical records submitted for review provided evidence that the patient had been utilizing cyclobenzaprine since at least 06/2013. This length of time exceeds guideline recommendations. As such, the request for cyclobenzaprine hydrochloride tablets 7.5 mg #120 (DOS: 08/27/2013) is non-certified.

Quazepam Tablets 15mg #30 (DOS: 8-27-13): 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/ACOEM Guidelines do not recommend the use of benzodiazepines due to their high risk of dependence. Most guidelines limit the use to 4 weeks and suggest weaning. It is unclear how long the patient has been utilizing this medication and therefore, guideline compliance and medical necessity cannot be determined. As such, the request for quazepam tablets 15 mg #30 (DOS: 08/27/2013) is non-certified.