

<b>Case Number:</b>	CM13-0044298		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	08/25/2010
<b>Decision Date:</b>	02/24/2014	<b>UR Denial Date:</b>	10/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/28/2013

### 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 Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 58-year-old female who reported an injury on 08/25/2010. The patient is currently diagnosed with cervical and lumbar discopathy, left shoulder impingement syndrome with partial rotator cuff tear, right shoulder impingement syndrome with labral tear and rotator cuff tear, double crush syndrome/carpal tunnel syndrome, and internal derangement of bilateral knees. The patient was seen by [REDACTED] on 06/17/2013. The patient reported persistent neck and lower back pain. A physical examination revealed tenderness to palpation of the cervical spine, paravertebral and upper trapezius muscle spasm, positive Spurling's maneuver and axial loading compression test, restricted range of motion, dysesthesia at the C6 and C7 dermatomes, tenderness to palpation with painful of bilateral shoulders, positive Hawkins impingement sign, positive Tinel's and Phalen's testing in the bilateral wrists, dysesthesia at the radial digits, weak grip strength bilaterally, tenderness to palpation with painful range of motion of the lumbar spine, positive lumbar spine, dysesthesia at the L5 dermatome, tenderness at the anterior joint line space of bilateral knees, and positive McMurray's sign. Treatment recommendations included continuation of current medication including ketoprofen, cyclobenzaprine, ondansetron, omeprazole, and Medrox pain relief ointment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**A retrospective request for Ketoprofen Capsules 75mg, one capsule by mouth every 8 hours: 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 California MTUS Guidelines state that 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. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain to multiple areas of the body. A satisfactory response to treatment has not been indicated. The patient's physical examination reveals no significant changes that would indicate functional improvement. Additionally, the California MTUS Guidelines state there is no evidence of long-term effectiveness for pain or function. Based on the clinical information received, the request is non-certified.

**A retrospective request for cyclobenzaprine hydrochloride tablets 7.5mg, one tablet by mouth every 8 hours as needed, not to exceed more than 3 per day, #120: 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 California MTUS Guidelines state that muscle relaxants are recommended as a non-sedating, second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to demonstrate palpable muscle spasm in the cervical spine. A satisfactory response to treatment has not been indicated. As guidelines do not recommend long-term use of this medication, the current request cannot be determined as medically appropriate. Therefore, the request is non-certified.

**A retrospective request for ondansetron ODT tablets 8mg, as needed for nausea, no more than twice a day, #30: 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 Guideline (ODG) Chronic Pain Chapter: Ondansetron, Antiemetics.

**Decision rationale:** The Official Disability Guidelines state that ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. Ondansetron is FDA

approved for nausea and vomiting secondary to chemotherapy and radiation treatment and has been FDA approved for postoperative use. The patient does not meet criteria as outlined by the Official Disability Guidelines for the use of this medication. Therefore, the request is non-certified.

**A retrospective request for omperaxole delayed-release capsules 20mg, one capsule by mouth every 12 hours as needed, #120: 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 California MTUS Guidelines state that proton pump inhibitors are recommended for patients with 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. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for a proton pump inhibitor. As such, the request is non-certified.

**A retrospective request for medrox pain relief ointment 120mg x 2 to be used topically, to be applied up to (4) times a day: 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 California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As per the clinical documentation submitted, there is no evidence of failure to respond to first-line oral medication prior to the initiation of a topical analgesic. Based on the clinical information received, the request is non-certified