

<b>Case Number:</b>	CM13-0057787		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	06/27/2011
<b>Decision Date:</b>	04/14/2014	<b>UR Denial Date:</b>	10/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2013

### 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 Family Practice, 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 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 a 39-year-old female who reported an injury on 06/27/2011 due to a slip and fall that reportedly caused injury to the patient's lower and upper back. The patient ultimately underwent lumbar fusion. The patient's pain was managed with multiple medications. The patient's most recent clinical evaluation documented the patient had pain rated at 6/10. Physical findings included tenderness over the sacroiliac joint with trigger points in the paraspinal musculature of the lumbar spine. The patient's diagnoses included chronic neck pain, cervical degenerative disc disease, cervical myofascial pain syndrome, cervical radiculopathy, lumbar laminectomy and fusion, and sacroiliitis on the right side. The patient's treatment plan included continuation of medications, trigger point injections of the lumbar spine, and surgical intervention of the cervical spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CYCLOBENZAPRINE HCL 7.5 MG #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**Decision rationale:** The requested Cyclobenzaprine HCL 7.5 mg #120 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends short durations of treatment of muscle relaxants not to exceed 2 to 3 weeks. The clinical documentation submitted for review does provide evidence that the patient has been on this medication since at least 03/2013. This is well an excess of guideline recommendations. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested Cyclobenzaprine HCL 7.5 mg #120 is not medically necessary or appropriate.

**ONDANSETRON 8MG #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary, updated 10/14/2013, Antiemetics (for opioid use)

**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, Anti-emetics

**Decision rationale:** The requested Ondansetron 8 mg #60 is not medically necessary or appropriate. Official Disability Guidelines recommend this medication for cancer treatment related nausea and vomiting, postsurgical nausea and vomiting, and acute gastritis. The patient's most recent clinical documentation does not support that the patient is suffering from a case of acute gastritis. There is no documentation that the patient has recently undergone surgical intervention that has caused nausea and vomiting and would require medication intervention. Additionally, there is no documentation that the patient is currently undergoing any cancer treatments. Therefore, the need for this medication is not clearly indicated. As such, the requested Ondansetron 8 mg #60 is not medically necessary or appropriate.

**QUAZEPAM 15MG #30:** Upheld

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

**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, Insomnia Treatments

**Decision rationale:** The requested Quazepam 15 mg #30 is not medically necessary or appropriate. The clinical documentation indicates that this medication is being prescribed to assist with sleep hygiene. However, an adequate assessment of deficits related to sleep hygiene were not provided within the documentation. Additionally, there is no documentation that the patient has been non-responsive to non-pharmacological insomnia treatments. Official Disability Guidelines do recommend short courses of the use of benzodiazepines in the treatment of

insomnia after there is a failure to respond to non-pharmacological treatments. As such, the requested Quazepam 15 mg #30 is not medically necessary or appropriate.