

<b>Case Number:</b>	CM13-0064885		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	02/07/2013
<b>Decision Date:</b>	06/05/2014	<b>UR Denial Date:</b>	11/15/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/12/2013

### 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 Occupational Medicine and is licensed to practice in Hawaii. 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 claimant injured his cervical spine on 02/07/13 and has chronic cervicgia. On 11/15/13, UR approved naproxen and tramadol but cyclobenzaprine and other medications were non-certified. The most recent program note dated 10/31/13 indicated that he was injured doing repetitive movements on his head and due to poor ergonomics. He complained of intermittent pain and had headaches and migraines. No other physical findings were noted. On 09/12/13, examination of the shoulders was documented but not the neck. He was given diagnoses of adhesive capsulitis and possible cervical radiculitis. His pattern of use of medications and his response to them are not described. There is no description of his reported headaches, including the pattern of pain, associated symptoms, or trials of treatment including medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

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

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Formulary, Cyclobenzaprine; Medications for Subacute and Chronic Pain.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines states for Cyclobenzaprine (Flexeril®), "Recommended as an option, using a short course of therapy. . . The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief." Additionally, MTUS and ODG outlines, "Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded." Flexeril also recommends "Do not use longer than 2-3 weeks" and is for "Short-term (2-3 weeks) treatment of muscle spasm associated with acute, painful musculoskeletal conditions." The medical documentation provided does not establish the need for long term/chronic usage of Flexeril, which MTUS guidelines advise against. Additionally, the medical records provided do not provide objective findings of acute spasms or diagnosis of acute spasm. In this case, the claimant's pattern of use of medications, including other first line drugs such as acetaminophen/NSAIDs, and his response to them, including relief of symptoms and documentation of functional improvement, have not been described. The request for Cyclobenzaprine Hydrochloride 7.5 mg, #120 is not medically necessary and appropriate.

**SUMATRIPTAN SUCCINATE 25MG #9 WITH REFILL:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://drugs.com/monograph/sumatriptan.html>

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Beithon J, Gallenberg M, Johnson K, Kildahl P, Krenik J, Liebow M, Linbo L, Myers C, Peterson S, Schmidt J, Swanson J. Diagnosis and treatment of headache. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2013 Jan.

**Decision rationale:** Sumatriptan is used for the treatment of migraines and/or cluster headaches. The listed guideline states "studies show that Sumatriptan and Naproxen sodium in combination may be more effective than either drug alone. However, there are no studies that demonstrate that sumatriptan 85 mg/naproxen sodium 500 mg is more effective than Sumatriptan and Naproxen sodium taken together. Therefore, a dose of Sumatriptan 100 mg and a dose of Naproxen sodium 550 mg taken at the same time are recommended." In this case, there is no description of the claimant's reported headaches, including the pattern of pain and associated symptoms, possible causes, trials of other conservative treatment measures, including medications, and the response to other treatment methods. It is not clear whether other medications have been tried and failed, including acetaminophen and NSAIDs. The request for Sumatriptan Succinate 25mg #9 with refill is not medically necessary and appropriate.

**ONDANSETRON ODT 8MG#30 WITH REFILL:** 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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physician's Desk Reference 2014.

**Decision rationale:** The PDR state that this medication is indicated for treatment of nausea but there is no documentation of this symptom in the records. The history and documentation do not objectively support the request for ondansetron (Zofran). No other indications for its use have been described. The request for Ondansetron ODT 8 mg # 30 with refill is not medically necessary and appropriate.

**OMEPRAZOLE DELAYED RELEASE 20MG #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms, and Cardiovascular Risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs/PPIs Page(s): 68.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines, regarding PPI's state, "patients at intermediate risk for gastrointestinal events and no cardiovascular disease:(1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 µg four times daily) or (2) a Cox-2 selective agent. Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary." In this case, there is no description of a history of or current presence or increased risk of gastrointestinal conditions to support the use of this medication. The medical necessity of this request has not been clearly demonstrated. The request for Omeprazole delayed released 20 mg # 120 is not medically necessary and appropriate.

**TRAMADOL HYDROCHLORIDE ER 150MG #90:** Upheld

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

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

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines, state, "Tramadol (Ultram®) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic." In this case, there is no documentation of trials and failure of or intolerance to other more commonly used first line drugs including acetaminophen and NSAIDs. The expected benefit or indications for the use of this medication have not been clearly described. Therefore, the request for Tramadol Hydrochloride ER 150 mg # 90 is not medically necessary and appropriate.

