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| Case Number: | CM14-0006031 | | |
| Date Assigned: | 03/03/2014 | Date of Injury: | 02/11/2009 |
| Decision Date: | 07/07/2014 | UR Denial Date: | 01/07/2014 |
| Priority: | Standard | Application Received: | 01/16/2014 |

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California. 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:

Review of progress notes indicates low back pain radiating to the left leg, all the way up to the foot, associated with numbness, weakness, and paresthesia. Patient also complains of neck pain radiating to bilateral upper extremities, left more than right, with numbness and tingling. Patient also experiences occipital headaches radiating anteriorly with floaters, smell sensitivity, and mild nausea. Findings of the cervical region include asymmetry, with tilting of the head and neck to the left; tenderness over the trapezial area; and restricted range of motion. There is decreased sensation over the C5 and C6 dermatomes, decreased left biceps reflex, and left scapular winging. Regarding the lumbar spine and lower extremities, findings include spasms of the lumbar region, quadriceps atrophy, decreased lumbar range of motion, positive straight leg raise test on the left, decreased left knee reflex, and decreased sensation on the left lateral thigh. Treatment to date has included NSAIDs, ice, heat, opioids, gabapentin, and lumbar epidural steroid injection. Utilization review from January 07, 2014 denied the retrospective requests (date of service 05/30/2102) for cyclobenzaprine hydrochloride 7.5mg #120, ondansetron ODT 8mg #60, omeprazole DR 20mg #120, and Medrox pain relief ointment 120mg x 2 #240. There is no documentation from the date of service of May 30, 2012 and earlier.

IMR ISSUES, DECISIONS AND RATIONALES

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

CYCLOBENZOPRINE HYDROCHLORIDE 7.5 MG, # 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 Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: As stated on CA MTUS Chronic Pain Medical Treatment Guidelines pages 63-66, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. They may be effective in reducing pain and muscle tension, and increasing mobility. However, they show no benefit beyond NSAIDs in pain and overall improvement. Patient is currently not using this medication, and does not present with acute exacerbation of pain. Utilization review dated January 07, 2014 indicates that this request is a retrospective request with date of service May 30, 2012. In this case, there is no documentation from the date of service of May 30, 2012 and earlier. There is no information to support this request. Therefore, the retrospective request for cyclobenzaprine hydrochloride 7.5mg #120 was not medically necessary.

ONDANSETRON ODT 8 MG, # 60: 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 Guidelines (ODG) Pain chapter, Antiemetics (for opioid nausea).

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, ondansetron is recommended for nausea and vomiting secondary to chemotherapy, radiation, and post-operative use. Acute use is FDA-approved for gastroenteritis. It is not recommended for nausea and vomiting secondary to chronic opioid use. Patient is currently not using this medication, and does not present with nausea or vomiting. There is no documentation that the patient had undergone chemotherapy, radiation therapy, or surgery. Utilization review dated January 07, 2014 indicates that this request is a retrospective request with date of service May 30, 2012. In this case, there is no documentation from the date of service of May 30, 2012 and earlier. There is no information to support this request. Therefore, the retrospective request for ondansetron ODT 8mg #60 was not medically necessary.

OMEPRAZOLE DELAYED RELEASE 20 MG, # 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 NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: According to page 68 of CA MTUS Chronic Pain Medical Treatment Guidelines, proton pump inhibitors are used in patients on Non-Steroidal Anti-Inflammatory Drugs (NSAID) therapy who are at risk for GI events. Risk factors include age > 65; history of peptic ulcer, Gastro Intestinal (GI) bleed, or perforation; concurrent use of Acetyl Salicylic Acid (ASA), corticosteroids, or anticoagulant; and high dose or multiple NSAID use. Use of proton-pump inhibitor (PPI) more than 1 year has been shown to increase the risk of hip fracture. Patient is currently using Protonix enteric coated tablets 40mg once a day. Utilization review dated January 07, 2014 indicates that this request is a retrospective request with date of service May 30, 2012. In this case, there is no documentation from the date of service of May 30, 2012 and earlier. There is no information to support this request. Therefore, the retrospective request for omeprazole delayed release 20mg #120 was not medically necessary.

MEDROX PAIN RELIEF OINTMENT 120 MG X 2, # 240: 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 Capsaicin, topical; Salicylate topicals; Topical analgesics Page(s): 28; 105; 111. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Topical Salicylates.

Decision rationale: An online search indicates that Medrox contains menthol 5%, capsaicin 0.0375%, and methyl salicylate 20%. California MTUS Chronic Pain Medical Treatment Guidelines, page 111 state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Regarding the Capsaicin component, CA MTUS Chronic Pain Medical Treatment Guidelines on page 28 states that topical Capsaicin is only recommended as an option when there is failure to respond or intolerance to other treatments; with the 0.025% formulation indicated for osteoarthritis. Regarding the Menthol component, CA MTUS does not cite specific provisions, but the ODG Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, methyl salicylate, or capsaicin, may in rare instances cause serious burns. Regarding the Methyl Salicylate component, CA MTUS states on page 105 that salicylate topicals are significantly better than placebo in chronic pain. Utilization review dated January 07, 2014 indicates that this request is a retrospective request with date of service May 30, 2012. In this case, there is no documentation from the date of service of May 30, 2012 and earlier. There is no information to support this request. Also, there is no guideline evidence to support the use of this compounded medication. Therefore, the request for Medrox pain relief ointment 120mg x 2 #240 was not medically necessary.