

<b>Case Number:</b>	CM14-0106131		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	09/07/2012
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	06/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/09/2014

### 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 Physical Medicine and Rehabilitation 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:

The injured worker is a 51-year-old male who reported an injury after exiting his patrol car quickly. He felt a sharp pain in his lower right back area on 09/07/2012. The clinical note dated 07/11/2014 indicates a diagnosis of disc disorder lumbar, internal derangement of the knee and lumbago. The injured worker reported constant pain in the low back that was aggravated by bending, lifting, twisting, pushing, pulling, prolonged sitting, prolonged standing, walking multiple blocks. The injured worker characterized his pain as sharp that radiated into the lower extremities. The injured worker rated his pain 7/10. The injured worker reported pain to the left knee that was aggravated by squatting, kneeling, ascending and descending stairs, and walking multiple blocks and prolonged standing. The injured worker reported some swelling and buckling of the knees. The injured worker characterized his pain as burning and reported his pain scale as 8/10. On physical examination of the knee, there was tenderness in the joint line with a positive patellar and grind test. There was crepitus with painful range of motion. The lumbar spine examination revealed tenderness upon palpation of the paravertebral muscles with spasms. The injured worker's seated nerve root test was positive. The injured worker's standing flexion and extension range of motion was guarded and restricted. The injured worker's treatment plan included refill medications, request for chiropractic of the lumbar spine and knee, and request for acupuncture treatment of the lumbar spine and knee. The injured worker's prior treatments included medication management. The injured worker's medication regimen was not provided for review. A request for authorization was not submitted for review, to include the date the treatment was requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ondansetron ODT 8mg #120: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Ondansetron ODT (Zofran).

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

**Decision rationale:** The request for Ondansetron ODT 8mg #120 is not medically necessary. The Official Disability Guidelines do not recommend Ondansetron (Zofran) for nausea and vomiting secondary to chronic opioid use. The documentation submitted did not indicate the injured worker had findings that he was nauseated or vomiting. In addition, it was not indicated the injured worker was utilizing this medication. Moreover, the request does not indicate a frequency. Therefore, the request is not medically necessary.

**Cyclobenzaprine HCL 7.5mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine HCL-Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

**Decision rationale:** The request for Cyclobenzaprine HCL 7.5mg #120 is not medically necessary. The CA MTUS guidelines recommend cyclobenzaprine (flexeril) as an option, using a short course of therapy. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system (CNS) depressant. The documentation submitted did not indicate if the injured worker had been utilizing this medication. Moreover, it was not indicated how long the injured worker had been utilizing this medication. If so, there is a lack of documentation of efficacy and functional improvement with the use of cyclobenzaprine. Additionally, the request does not indicate a frequency. Therefore, the request for cyclobenzaprine is not medically necessary.

**Medrox pain relief ointment 120gm x2 #240: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medrox - topical analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): 111-112.

**Decision rationale:** The request for Medrox pain relief ointment 120gm x2 #240 is not medically necessary. The California Chronic Pain Medical Treatment Guidelines state topical

analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines also indicate any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Medrox contains methyl salicylate, menthol, and capsaicin. It was not indicated if the injured worker had tried and failed antidepressants or anticonvulsants. In addition, it was not indicated if the injured worker had not responded or was intolerant to other treatments. Additionally, capsaicin is generally available as a 0.025% formulation. However, Medrox contains 0.037%. This exceeds the guidelines' recommendation. Furthermore, the provider did not indicate a rationale for the request. Moreover, the request does not indicate a frequency. Therefore, the request is not medically necessary.

**Cidaflex tablets #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cidaflex; Glucosamine (and Chondroitin Sulfate).

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

**Decision rationale:** The request for Cidaflex tablets #120 is not medically necessary. The Official Disability Guidelines indicate Cidaflex is recommended an option (glucosamine sulfate only) given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. The Glucosamine Chondroitin Arthritis Intervention Trial (GAIT) funded by the National Institutes of Health concluded that glucosamine hydrochloride (GH) and chondroitin sulfate were not effective in reducing knee pain in the study group overall, but the GAIT investigators did not use glucosamine sulfate (GS). (Distler, 2006) Despite multiple controlled clinical trials of glucosamine in osteoarthritis (mainly of the knee), controversy on efficacy related to symptomatic improvement continues. It is not indicated if the injured worker had been utilizing this medication. In addition, there was a lack of documentation of efficacy and functional improvement with the use of this medication. Furthermore, the request does not indicate a dosage or frequency for this medication. Therefore, the request is not medically necessary.