

Case Number:	CM14-0108392		
Date Assigned:	08/01/2014	Date of Injury:	08/19/2011
Decision Date:	12/23/2014	UR Denial Date:	06/16/2014
Priority:	Standard	Application Received:	07/11/2014

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, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 56 year old male with a work injury dated 8/19/11. The diagnoses include cervical discopathy; left shoulder impingement, cubital/carpal tunnel syndrome/double crush syndrome. Under consideration are requests for multiple medications. Per documentation there is a 3/8/12 document that states that the patient complains of intermittent cervical spine pain that radiates to the left upper extremity with paresthesia in the left index finger. The patient has complaints of constant left shoulder and left elbow and forearm pain with associated tingling and numbness in the digits. The treatment plan includes Naproxen Sodium 550mg #100, Tizanidine HCl, 4mg # 120, Ondansetron Omeprazole; and Medrox pain relief ointment 120gm x2. The patient is currently temporarily totally disabled. A 4/19/12 progress note states that the patient has some residual symptomatology in his cervical spine. He has continued symptomatology in the cervical spine with chronic headaches and tension between shoulder blades. The symptomatology in the patient's left shoulder and left elbow and arm has not changed significantly. Examination of the cervical spine is unchanged. There is tenderness at the cervical paravertebral muscles and upper trapezial muscles with spasm. Axial loading compression test and Spurling's maneuver are positive. There is painful and restricted cervical range of motion. There is dysesthesia at the C5 to C7 dermatomes. Examination of the left shoulder is essentially unchanged. There is tenderness in the anterior glenohumeral region and subacromial space with a positive Hawkins' impingement sign. There are no signs of instability. Apprehension test is negative. Examination of the left elbow and arm is essentially unchanged. There is positive Tinsel's in the cubital fossa. There is reproducible symptomatology in the ulnar two digits. There is also a positive palmar compression test subsequent to Phalen's maneuver with reproducible symptomatology in the median nerve distribution, the left side more

pronounced than on the right, consistent with carpal tunnel. Double crush syndrome has been established. The treatment plan states that the patient awaits a cervical injection. There is a refill of meds. The physician states he did not want his patient back at work yet. A 9/5/12 document states that the patient has been diagnosed with double crush syndrome. He has continued symptomatology in the cervical spine with chronic headaches, tension between the shoulder blades and migraines with radicular pain component. He also has signs and symptoms consistent with left carpal tunnel syndrome. He has some atrophy in the left upper extremity. The treatment plan includes a refill of medications. The patient is working light duty.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine 4mg, #120 with DOS 03/08/12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants for pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex, generic available) Muscle relaxants (for pain) Page(s): 66, 63.

Decision rationale: Tizanidine 4mg, #120 with DOS 03/08/12 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that muscle relaxants are recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Tizanidine is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. The documentation indicates that the patient has chronic low back pain rather than acute. Tizanidine is recommended for short term use rather than chronic use. The request for Tizanidine 4mg, # 120 is not medically necessary.

Ondansetron 8mg, #30 x3 with DOS 03/08/12, 04/19/12, and 09/05/12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines-Pain

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®); Antiemetics (for opioid nausea)

Decision rationale: Ondansetron 8mg #30 X3 with DOS 03/08/12, 04/19/12, and 09/05/12 is not medically necessary per ODG guidelines. The MTUS does not specifically address Ondansetron. The ODG does not recommend ondansetron for nausea/vomiting secondary to chronic opioid use but does recommend for acute use per FDA indications including: to chemotherapy and radiation treatment, postoperative use., or acutely used in for gastroenteritis. There is no documentation that this medication is being used postoperatively, for acute gastroenteritis, or secondary to chemo or radiation treatment therefore this medication is not medically necessary.

Medrox 120gm, x3 with DOS 03/08/12, 04/19/12, and 09/05/12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin, topical, Topical analgesics Page(s): 28, 111-113. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence:
<http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=27a9a7ac-6e1c-4564-bd1b-d6b42edcadaf>

Decision rationale: Medrox 120gm, x3 with DOS 03/08/12, 04/19/12, and 09/05/12 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. A review of Medrox cream online revealed that the active ingredients are Methyl Salicylate 20.00%; Menthol 5.00%; and Capsaicin 0.0375%. The MTUS states that there are no studies of a 0.0375% formulation of capsaicin. There is no current indication that this increase over a 0.025% formulation of capsaicin would provide any further efficacy. Additionally, capsaicin is recommended topically only as an option in patients who have not responded or are intolerant to other treatments. Per guidelines, Salicylate topicals including methyl salicylate and menthol are recommended; however, the patch formulation of both of these formulations in combination with Capsaicin are not specifically mentioned in the MTUS. The guidelines additionally add that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The documentation does not indicate intolerance to oral medications or extenuating circumstances to go against guideline recommendations. Therefore, the request for Medrox 120gm, x3 with DOS 03/08/12, 04/19/12, and 09/05/12 is not medically necessary.

Sumatriptan 25mg, #9 x2 with DOS 04/19/12 and 09/05/12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines-Head

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Triptans-head

Decision rationale: Sumatriptan 25mg, #9 x2 with DOS 04/19/12, 09/05/12 is not medically necessary as written per the ODG guidelines. The MTUS does not address Sumatriptan. The ODG recommends triptans for migraine sufferers. The ODG states that at marketed doses, all oral triptans (e.g., sumatriptan, brand name Imitrex) are effective and well tolerated. The documentation indicates on DOS 4/19/12 there is no description of a migrainous headache. There is a description of a migrainous headache on 9/5/12. The request as written for Sumatriptan on both dates DOS 4/19/12 and 9/5/12 is not medically necessary due to no documentation supporting a migraine headache for DOS 4/19/12.

Cyclobenzaprine 7.5mg, #120 with DOS 09/05/12: 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 Cyclobenzaprine (Flexeril) Page(s): 41-42, 64.

Decision rationale: Cyclobenzaprine 7.5mg, #120 with DOS 09/05/12 is not medically necessary per the MTUS Guidelines. The guidelines state that Cyclobenzaprine is not recommended to be used for longer than 2-3 weeks. The documentation indicates that the patient has already been on Cyclobenzaprine. There are no extenuating circumstances documented that would necessitate continuing this medication beyond the 2-3 week time frame. The request for Cyclobenzaprine 7.5mg, #120 is not medically necessary.