

<b>Case Number:</b>	CM14-0014475		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	10/13/2011
<b>Decision Date:</b>	06/30/2014	<b>UR Denial Date:</b>	01/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/05/2014

### 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 & Rehabilitation and is licensed to practice in Illinois. 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 58-year-old male with a reported injury date on 10/14/2011; the mechanism of injury was not provided. The injured worker's diagnoses include cervical discopathy with radiculopathy, carpal tunnel/double crush syndrome, and status post right shoulder arthroscopy. The clinical note dated 11/20/2013 noted that the injured worker has pain in the left hand. It was also noted that the injured worker was scheduled to undergo a surgical intervention in regards to the left hand. It was also noted that the patient's cervical spine, right shoulder, left elbow and right wrist/hand symptomatology had not changed. Upon examination of the cervical spine, it was noted that the injured worker had tenderness at the cervical paravertebral muscles, a positive axial loading compression test and a positive Spurling's maneuver. Examination of the right shoulder noted tenderness at the right shoulder anteriorly and residual weakness. On examination of the left wrist, it was noted that there were positive Tinel's and Phalen's signs, pain with terminal flexion and dysesthesia at the radial digits as well as a weak grip. The treatment plan included the ordering of postoperative medication, which were noted to include Naprosyn 550 mg taken 1 tab every 12 hours, cyclobenzaprine 7.5 mg 1 tablet every 8 hours, ondansetron 8 mg taken no more than twice a day, omeprazole 20 mg taken once every 12 hours and tramadol taken 1 tablet a day as needed for pain. The clinical note dated 11/27/2013 noted that the injured worker had cancelled his surgery. The Request for Authorization forms for the requested services were not provided in the medical documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

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

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

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

**Decision rationale:** The California MTUS Guidelines state that muscle relaxants may be recommended as an option for chronic pain, using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses are the best option. The guidelines also state that cyclobenzaprine is not recommended to be used for longer than 2 to 3 weeks. This request exceeds the recommended timeframe of use. Additionally, this medication was requested for postoperative treatment; however, it was documented that the surgery was cancelled. As such, this request is not medically necessary.

**ONDANSETRON 8 MG # 30 X 2:** 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), Pain Chapter.

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

**Decision rationale:** The Official Disability Guidelines do not recommend the use of ondansetron for nausea and vomiting secondary to chronic opioid use. However, it is approved for nausea and vomiting secondary to chemotherapy and radiation treatment and for postoperative treatment of nausea following anesthesia. There was a lack of evidence within the documentation provided that the injured worker was experiencing symptomatology that would benefit from the use of this medication. Additionally, this medication was requested for postoperative treatment; however, it was documented that the surgery was cancelled. As such, this request is not medically necessary.

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

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Central acting analgesics Page(s): 75.

**Decision rationale:** The California MTUS Guidelines state that tramadol may be recommended for the treatment of chronic pain. The guidelines also state that ongoing management of pain relief with this medication must include ongoing review and documentation of adequate pain relief, functional status, appropriate medication use and side effects. It was documented that this

medication was requested for postoperative treatment; however, it was also documented that the surgery was cancelled. As such, this request is not medically necessary.