

<b>Case Number:</b>	CM14-0046910		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	03/15/2011
<b>Decision Date:</b>	09/25/2014	<b>UR Denial Date:</b>	03/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/14/2014

### 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 Family Practice and is licensed to practice in Texas and Georgia. 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 on 11/27/2012. The mechanism of injury was not provided for clinical review. The diagnoses included status post left shoulder arthroscopy with subacromial arch decompression, a Mumford resection and rotator cuff repair, bilateral shoulder impingement syndrome, left cubital tunnel syndrome. Previous treatments included surgery, functional capacity evaluation, and medication. Within the clinical note dated 02/19/2014 it was reported the injured worker reported significant improvement of the rotator cuff since surgery. On the physical examination the provider noted the injured worker had tenderness of the subacromial space and acromioclavicular joint. The injured worker had a positive impingement, Hawkins test. The provider noted the injured worker had tenderness at the olecranon fossa. The injured worker had a positive Tinell's sign at the left elbow. The request submitted is for Cyclobenzaprine HCL, Ondansetron ODT, Tramadol HCL ER, and Terocin patch. However, a rationale was not provided for clinical review. A Request for Authorization was submitted and dated on 03/12/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

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

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines- Muscle Relaxants.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

**Decision rationale:** The request for Cyclobenzaprine HCL 7.5 mg #120 is not medically necessary. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. The guidelines note the medication is not recommended to be used for longer than 2 to 3 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the injured worker had been utilizing the medication for an extended period of time since at least 02/2014 which exceeds the guideline recommendation of short term use of 2 to 3 weeks. Therefore, the request is not medically necessary.

**Ondansetron ODT 8mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC 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, Zofran.

**Decision rationale:** The request for Ondansetron ODT 8mg #60 is not medically necessary. The Official Disability Guidelines do not recommend the use of Ondansetron for nausea and vomiting secondary to chronic opioid use. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. There is lack of clinical documentation indicating the injured worker is treated for nausea or vomiting secondary to chronic opioid use. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

**Tramadol HCL ER 150mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78.

**Decision rationale:** The request for Tramadol HCL ER 150 mg #90 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. The provider did not document an adequate and complete pain assessment within the

documentation. Additionally, the use of a urine drug screen as not provided for clinical review. Therefore, the request is not medically necessary.

**Terocin Patch #30:** 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 Topical NSAIDs Page(s): 111-112.

**Decision rationale:** The request for Terocin patch #30 is not medically necessary. The California MTUS Guidelines recommend topical NSAIDs for the use of osteoarthritis and tendonitis, in particular that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency, dosage and treatment site of the medication. Additionally, the injured worker has been utilizing the medication since at least 02/2014, which exceeds the guideline recommendation of short term use of 4 to 12 weeks. Therefore, the request is not medically necessary.