

<b>Case Number:</b>	CM14-0074286		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	06/01/2008
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	04/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/21/2014

### 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 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 claimant is a 60 year old female presenting with neck and low back pain following a work related injury on 06/01/2008. The claimant is diagnosed with cervical and lumbar discopathy with radiculitis and right greater trochanteric bursitis. On 11/21/12, the claimant reported increased pain in the lumbar spine. The physical exam showed cervical spine revealed tenderness of the paravertebral muscles and upper trapezial muscles with spasm, axial loading compression test, and Spurling's maneuver were positive, lumbar spine with pain and tenderness in the mid to distal lumbar segments, standing flexion and extension are guarded and restricted, reproducible pain with standing flexion and extension. The claimant was diagnosed with L3-4 root type pain in the right lower extremity, extending from the right flank into the right groin and inguinal region.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ondansetron 8mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Physician Desk Reference.

**Decision rationale:** Ondansetron 8 mg # 60 is not medically necessary. The MTUS and ODG do not present a statement on this medication. The physician desk reference states that this medication is indicated for anti-nausea medication treatment of chemotherapy and related emesis. The claimant was prescribed this medication for nausea associated with his current medication and there is a lack of documentation of chemotherapy associated nausea or emesis; therefore the request of Ondansetron 8mg #60 is not medically necessary and appropriate.

**Medrox 120 gram # 2:** Upheld

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

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

**Decision rationale:** Medrox 120 grams # 2 is not medically necessary. According to California MTUS, 2009, chronic pain, page 111 California MTUS guidelines does not cover topical analgesics that are largely experimental in use with a few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Medrox is a compounded drug containing Salicylate, Capsaicin, and Menthol. Per MTUS page 112, Capsaicin is indicated for fibromyalgia, osteoarthritis and non-specific back pain in patients who have not responded or are intolerant to other treatments. At that point only the formulations of 0.025% is recommended as increasing the concentration has not been found to improve efficacy. Medrox contains 0.0375% capsaicin and not recommended. In regards to salicylate, which is a topical NSAID, MTUS guidelines indicates this medication for Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. It is also recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of pain associated with the spine, hip or shoulder. The provider recommended Medrox for the claimant's chronic pain; therefore, the requested Medrox 120 gram #2 is not medically necessary and appropriate.

**Cyclobenzaprine 7.5mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment for Workers Compensation (TWC), Pain Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-spasmodic Page(s): 64.

**Decision rationale:** Cyclobenzaprine 7.5mg #120 is not medically necessary for the client's chronic medical condition. The peer-reviewed medical literature does not support long-term use of Cyclobenzaprine in chronic pain management. Additionally, Per CA MTUS Cyclobenzaprine is recommended as an option, using a short course of therapy. The effect is greatest in the first 4

days of treatment, suggesting that shorter courses may be better. (Browning, 2001). As per MTUS, the addition of Cyclobenzaprine to other agents is not recommended. In regards to this claim, Cyclobenzaprine was prescribed for long term use and in combination with other medications. Therefore, Cyclobenzaprine 7.5mg #120 is not medically necessary and appropriate.

**Cidaflex tablets #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine/Chondroitin Page(s): 47.

**Decision rationale:** Cidaflex tablets #120 is a brand name for the nutritional supplement Glucosamine/Chondroitin. Cidaflex is not medically necessary. Recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. Studies have demonstrated a highly significant efficacy for crystalline Glucosamine Sulphate (GS) on all outcomes, including joint space narrowing, pain, mobility, safety, and response to treatment, but similar studies are lacking for glucosamine hydrochloride. The provider prescribed Cidaflex for claimant's chronic neck and back pain which are not associated with osteoarthritis; therefore, the requested Cidaflex tablets #120 is not medically necessary and appropriate.