

<b>Case Number:</b>	CM14-0087322		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	09/28/2011
<b>Decision Date:</b>	09/22/2014	<b>UR Denial Date:</b>	05/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/10/2014

### 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 Internal 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 employee was a 55 year old male who sustained an industrial injury on 09/28/11. The mechanism of injury was falling out of a truck on his back while stepping out of it. His symptoms included pain to his head, neck, left shoulder, cervical spine, lower back, right foot and right wrist. His diagnoses included cervical disc displacement with cervical musculoligamentous injury and sprain/strain. His pertinent prior diagnosis also included dizziness in 2013. His medications included Ambien, Naproxen, Protonix, Gabapentin and Tramadol. He was status post bilateral shoulder. He had an Internal Medicine preoperative clearance examination on January 13, 2014. He was found to have normal electrocardiogram and was cleared for left shoulder arthroscopic surgery. His MRI of cervical spine that was done on Dec 18, 2013 showed disc desiccation at C2-C3 down to C6-C7 with associated loss of disc height at C5-C6. There were broad-based posterior disc herniations at C3-C4 and C4-C5 causing stenosis the spinal canal. At C5-C6, there was focal left paracentral posterior disc herniation indenting the anterior aspect of the spinal cord with bilateral uncovertebral joint degenerative changes. An MRI of the lumbar spine at the same time showed disc herniation at T12 and L1, L1-L2, L2-L3, L3-L4, L4-L5 and L5-S1. These were causing stenosis of the spinal canal and also of the right neural foramina. He had a left shoulder arthroscopy with subacromial decompression and arthrotomy with rotator cuff repair on Jan 21, 2014. He was seen by a treating provider on March 17, 2014. His subjective symptoms included chronic pain in left shoulder that was improving after the rotator cuff repair. On examination, he was noted to have increased range of motion on elevation of upper extremity. His diagnosis included shoulder impingement. He was seen by the Neurologist on 04/01/14 and was found to have subjective complaints of headaches, tinnitus, tremors, neck pain and back pain. His medications included Naproxen, Neurontin, Ultram, Protonix, Ambien, vitamins and blood pressure medication.

Pertinent physical exam findings included emotional distress, tenderness to palpation of cervical spinous processes and limited lower back range of motion. His diagnoses included chronic lumbosacral spine disc herniation with radicular symptoms, cervical disc herniation and likely muscle traction like recurrent headaches. He was also seen by the treating provider on 04/17/14. His subjective complaints included dull sharp achy neck pain that was 6/10 in intensity, aggravated by sudden movement, prolonged sitting and watching TV, prolonged standing and prolonged walking, radiating down to left arm, causing headaches. He also had lumbar sharp severe 10/10 pain. He also had 5/10 intensity right wrist pain. Pertinent objective findings included tenderness to palpation in cervical and lumbar paravertebral muscles and tenderness to palpation of wrist. The diagnoses included cervical disc displacement, cervical sprain/strain, lumbar derangement, lumbar dysfunction, right wrist sprain/strain. Review of medical records provided revealed diagnoses of dizziness without mention of vertigo. The request was for meclizine 25mg.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Meclizine 25mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-49.

**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: Meclizine: Drug information. Lexicomp. Uptodate.

**Decision rationale:** The employee was being treated for neck pain, cervical disc disease, lumbar disc disease, wrist pain and shoulder impingement. He had a diagnosis of dizziness. Treatment included shoulder surgery, oral medications including Naproxen and a request was submitted for Meclizine. Meclizine is a Histamine H1 antagonist and is an antiemetic. The product and above evidence indicate that Meclizine is used for motion sickness and for management of vertigo in vestibular diseases. The clinical documentation submitted for review does not reveal ongoing dizziness, vertigo or motion sickness. It is also unclear if any workup was done for the dizziness and there is no documented diagnosis of vertigo. Hence the request for Meclizine 25mg is not medically necessary or appropriate.