

Case Number:	CM14-0004398		
Date Assigned:	02/05/2014	Date of Injury:	02/11/2009
Decision Date:	04/13/2015	UR Denial Date:	01/03/2014
Priority:	Standard	Application Received:	01/13/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: District of Columbia, Virginia
Certification(s)/Specialty: Internal Medicine

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 66 year old female, who sustained an industrial injury on 2/11/2009. The diagnoses have included degeneration of cervical intervertebral disc, cervical disc displacement, lumbar disc displacement, cervical radiculitis and lumbar radiculopathy. Treatment to date has included medication. According to the Primary Treating Physician's Progress Report dated 7/12/2012, the injured worker was seen for an orthopedic preoperative evaluation. The injured worker complained of neck pain with stiffness. She complained of right shoulder pain and left wrist pain. Exam of the cervical spine revealed tenderness at the cervical paravertebral muscles and upper trapezial muscles with spasm. Exam of the right shoulder revealed tenderness and a positive impingement sign. Exam of the lumbar spine revealed tenderness at the lumbar paravertebral muscles. Exam of the left wrist revealed positive Finkelstein's sign and tenderness at the first dorsal compartment. Left wrist surgery was discussed. Postoperative medications were dispensed. The Request for Authorization dated 12/17/2013 was for retro authorization for medications for date of service 7/12/2012, Levofloxacin, Medrox, Omeprazole Delayed-Release and Ondansetron. On 1/3/2014, Utilization Review (UR) non-certified a request for Ondansetron ODT tablets 8mg #60, Omeprazole Delayed-Release Capsules 20mg #120 and Medrox Pain Relief Ointment 120gm #240. The Medical Treatment Utilization Schedule (MTUS), American College of Occupational and Environmental Medicine (ACOEM) Guidelines and Official Disability Guidelines (ODG) were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF ONDANESTRON ODT TABLETS 8MG, #60 (DOS: 09/21/11):

Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.rxlist.com/zofran-drug/indications-dosage.htm>.

Decision rationale: <http://www.rxlist.com/zofran-drug/indications-dosage.htm>. MTUS and ACOEM do not address this medication so additional sources were sought. Per guidelines cited and given that this patient had no issues with nausea; this medication would not be indicated. Zofran indications: 1. Prevention of nausea and vomiting associated with highly emetogenic cancer Chemotherapy, including cisplatin 50 mg/m². 2. Prevention of nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy. 3. Prevention of nausea and vomiting associated with radiotherapy in patients receiving total body irradiation, single high-dose fraction to the abdomen, or daily fractions to the abdomen. 4. Prevention of postoperative nausea and/or vomiting. As with other antiemetics, routine prophylaxis is not recommended for patients in whom there is little expectation that nausea and/or vomiting will occur postoperatively. In patients where nausea and/or vomiting must be avoided postoperatively, ZOFRAN Tablets, ZOFRAN ODT Orally Disintegrating Tablets, and ZOFRAN Oral Solution are recommended even where the incidence of postoperative nausea and/or vomiting is low.

PRESCRIPTION OF OMEPRAZOLE DELAYED-RELEASE CAPSULES 20MG, #120 (DOS: 09/21/11): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792 Page(s): 68.

Decision rationale: Per MTUS: NSAIDs, GI symptoms & cardiovascular risk, Recommend with precautions as indicated below. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular riskfactors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. Recommendations, Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.). Patients at intermediate risk for gastrointestinal events and no cardiovascular disease : (1) Anon-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily)

or misoprostol (200g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use(> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2selective agent plus a PPI if absolutely necessary. Per review of the clinical data provided, the patient was not on NSAIDS and did not have issues with gastritis or esophagheal reflux. This medication would not be indicated.

PRESCRIPTION OF MEDROX PAIN RELIEF OINTMENT 120GM, #240 (DOS: 09/21/11): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792 Page(s): 75,91,124-127.

Decision rationale: MTUS: 75, 91,124-127Medrox contains capsaicin/menthol/methyl salicylate ointment. Per MTUS: Recommended only as an option in patients who have not responded or are intolerant to other treatments. Formulations: Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain). There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Indications: There are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific back pain, but it should be considered experimental in very high doses. Although topical capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in conjunction with other modalities) in patients whose pain has not been controlled successfully with conventional therapy. The number needed to treat in musculoskeletal conditions was 8.1. The number needed to treat for neuropathic conditions was 5.7. (Robbins, 2000) (Keitel, 2001) (Mason-BMJ, 2004) The results from this RCT support the beneficial effects of 0.025% capsaicin cream as a first-line therapy for OA pain. (Altman, 1994) Mechanism of action: Capsaicin, which is derived from chili peppers, causes vasodilation, itching, and burning when applied to the skin. These actions are attributed to binding with nociceptors, which causes a period of enhanced sensitivity followed by a refractory period of reduced sensitivity. Topical capsaicin is superior to placebo in relieving chronic neuropathic and musculoskeletal pain. Capsaicin produces highly selective regional anesthesia by causing degeneration of capsaicin-sensitive nociceptive nerve endings, which can produce significant and long lasting increases in nociceptive thresholds. (Maroon, 2006). Adverse reactions: Local adverse reactions were common (one out of three patients) but seldom serious (burning, stinging, erythema). Coughing has also been reported. See also CRPS, medications; Topical analgesics. For stimulus-independent pain, Mexiletine, lidocaine patches and capsaicin are used but efficacy is not convincing. Methyl salicylate: Recommended. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. (Mason-BMJ, 2004) See also Topical analgesics; & Topical analgesics, compounded. In MTUS section addressing topical analgesics, it is recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for

neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The role of capsaicin is still not recommended for the chronic pain. It, being a part of Medrox formulation, is therefore, is not indicated. Therefore, this is not medically indicated for this patient's condition.