

<b>Case Number:</b>	CM14-0138645		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	04/25/2012
<b>Decision Date:</b>	07/01/2015	<b>UR Denial Date:</b>	08/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/27/2014

### 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: Texas, Florida  
Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 56 year old male, who sustained an industrial injury on 4/25/12. Initial complaints are cumulative in nature. The injured worker was diagnosed as having cervical/lumbar discopathy; bilateral shoulder impingement; carpal tunnel/double crush syndrome. Treatment to date has included medications. Diagnostics included x-rays of cervical, lumbar, bilateral shoulders, bilateral forearms (6/7/12). Currently, the PR-2 notes dated 6/7/12 indicated the injured worker complains of intermittent pain in the cervical spine that radiates to the upper extremity. The pain is aggravated by repetitive motions of the neck, pushing, pulling, forward reaching, and working at or above the shoulder level and lifting. There is no paresthesia in the upper extremities. The lumbar spine pain is noted as constant pain in the low back that occasionally radiates down the right lower extremity. The pain is aggravated by bending, lifting, twisting, pushing, pulling and standing or sitting greater than 15-30 minutes. There is no paresthesia in the lower extremities. There is daily pain in both shoulders that is aggravated by forward reaching, lifting, pushing, pulling, and working at or above the shoulder level. He also complains of intermittent pain in the left forearm that is aggravated by lifting, gripping, grasping, pushing and pulling. The provider's notes state the injured worker was not taking medications and he has had only left wrist surgery in 1990. A physical examination is documented as well as review of radiographic examinations of the cervical, lumbar, bilateral shoulders and bilateral forearms. X-rays noted cervical and lumbar spondylosis and other areas are essentially normal. The provider has requested retrospective medications: Ondansetron ODT tablets 8mg #30 x 2 QTY: 60 DOS: 06/07/12, Sumatriptan Succinate tablets 25mg # 9 x 2 DOS: 06/07/12, Cyclobenzaprine Hydrochloride tablets 7.5mg #120 DOS 06/07/12 and Medrox Pain Relief Ointment 120mg x 2 QTY: 240 DOS: 06/07/12.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Ondansetron ODT tablets 8mg #30 with 2 refills (DOS: 06/07/12): 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:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Opioids.

**Decision rationale:** The CA MTUS and the ODG guidelines did not recommend the chronic use of anti-emetics during long term opioid treatment. The guidelines noted that the nausea and vomiting associated with chronic opioid treatment is self limiting. It is recommended that the use of anti-emetic be limited to short term use in the acute care setting and during chemotherapy and acute migraine treatments. The records did not show documentations of these indications for the use of Ondansetron. The criteria for the use of Ondansetron 8mg #30 QTY 2 DOS 06/07/2012 was not met. Therefore, this request is not medically necessary.

**Sumatriptan Succinate tablets 25mg #9 with 2 refills (DOS: 06/07/12): 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)-TWC Head Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Head.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that anti-migraine medications can be utilized for the prevention and treatment of chronic headache and migraine. The records did not show documentation of subjective or objective findings consistent with headache or migrainous syndromes. There is no documentation for the indication for the use of Sumatriptan. The criteria for the use of Sumatriptan succinate 25mg X9 QTY 2. DOS 06/07/2012 was not met. Therefore, this request is not medically necessary.

**Cyclobenzaprine Hydrochloride tablets 7.5mg #120 (DOS: 06/07/12): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41-42. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Muscle relaxants.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that muscle relaxants can be utilized for the short term treatment of exacerbation of musculoskeletal pain that did not respond to standard treatment with NSAIDs and PT. The chronic use of muscle relaxants can be

associated with the development of tolerance, dependency, addiction, sedation and adverse interaction with the other sedatives. The records show that the patient had utilized muscle relaxants longer than the guidelines recommend maximum 4 to 6 weeks period. The criteria for the use of cyclobenzaprine HCL 7.5mg #120 DOS 06/07/2012 was not met. Therefore, this request is not medically necessary.

**Medrox Pain Relief Ointment 120mg with 2 refills (DOS: 06/07/12): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Topical Analgesics.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that topical analgesic products can be utilized for the treatment of localized neuropathic pain when treatments with first line anticonvulsant and antidepressant medications. The records did not show subjective or objective findings consistent with the diagnosis of localized neuropathic pain. There is no documentation of failure of first line medications. The guidelines recommend that topical products be utilized and evaluated individually for efficacy. The Medrox product contains menthol 5% / capsaicin 0.0375% / methyl salicylate 20%. There is lack of guidelines or FDA support for the chronic use of menthol and methyl salicylate in the treatment of musculoskeletal pain. The criteria for the use of Medrox 120mg QTY 2. 240DOS 06/07/2012 was not met. Therefore, this request is not medically necessary.