

Case Number:	CM15-0000413		
Date Assigned:	01/12/2015	Date of Injury:	09/16/2010
Decision Date:	04/08/2015	UR Denial Date:	12/10/2014
Priority:	Standard	Application Received:	01/02/2015

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: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 57-year-old female who reported injury on 09/16/2010. The documentation indicated the injured worker utilized ondansetron and Medrox pain ointment since at least 12/19/2011. There was no Request for Authorization submitted for review for the date of service 01/31/2011 and there were no office notes submitted for review dated 01/31/2011. The documentation closest to the request was dated 12/19/2011. The documentation indicated the injured worker had been recommended to undergo surgical intervention with respect to the cervical spine. The injured worker had symptomatology in the cervical spine with extension to the upper extremity, and generalized weakness and numbness in the bilateral hands and arms. There was tenderness in the paravertebral muscles. The seated nerve root test was positive. The x-rays failed to reveal hardware failure. The diagnosis included cervical discopathy and lumbar discopathy. The treatment plan included surgical intervention and the continued use of ondansetron 8 mg #30 x2 for nausea, and to continue with Medrox ointment for the temporary relief of minor aches and pains up to 4 times per day. There was no rationale for the use of Cidaflex.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Ondansetron ODT 8 mg #30 x 2 with a dos of 1/31/2011: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Ondansetron.

Decision rationale: The Official Disability Guidelines indicate that ondansetron is not recommended for the treatment of nausea and vomiting secondary to opioid use. There was a lack of documented rationale. There was a lack of documentation for the date of service 01/31/2011. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documentation indicating a necessity for 30 tablets x2. Given the above and the lack of documentation, the retrospective request for ondansetron ODT 8 mg #30 x 2 with a DOS of 1/31/2011 is not medically necessary.

Retrospective request for Medrox pain relief ointment 120 gm x 2 QTY 240 with a dos of 1/31/2011: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Salicylate; Topical Analgesic; Topical Capsaicin Page(s): 105; 111; 28. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Medrox Online Package Insert.

Decision rationale: The California Medical Treatment Utilization Schedule indicates that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety "are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments. 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. Additionally it indicates that Topical Salicylates are approved for chronic pain. According to the Medrox package insert, Medrox is a topical analgesic containing Menthol 5.00% and 0.0375% Capsaicin and it is indicated for the "temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness, and stiffness." The clinical documentation submitted for review failed to provide documentation from 01/31/2011. There was a lack of documentation of objective functional improvement and an objective decrease in pain. The request as submitted failed to indicate the frequency and the body part to be treated. There was a lack of documentation indicating a necessity for 2 tubes of Medrox ointment. There was a lack of documentation indicating antidepressants and anticonvulsants had failed, and that there was a necessity for capsaicin over the formulation of

0.025%. Given the above, the retrospective request for Medrox pain relief ointment 120 gm x 2 QTY 240 with a DOS of 1/31/2011 is not medically necessary.

Retrospective request for Cidaflex tablets #120 with a dos of 1/31/2011: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chondroitin Sulfate/Glucosamine Hydrochloride Page(s): 50.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines do not recommend Cidaflex, which is a combination of Chondroitin Sulfate/Glucosamine Hydrochloride for treatment of knee in patients with moderate arthritis pain. The clinical documentation submitted for review failed to provide documentation of exceptional factors. There is a lack of documentation of objective functional improvement and objective decrease in pain. The request as submitted failed to provide documentation of the frequency for the requested medication. There was no documentation from 01/31/2011. Given the above, the retrospective request for Cidaflex tablets #120 with a DOS of 1/31/2011 is not medically necessary.