

<b>Case Number:</b>	CM15-0100929		
<b>Date Assigned:</b>	06/03/2015	<b>Date of Injury:</b>	07/30/2014
<b>Decision Date:</b>	09/23/2015	<b>UR Denial Date:</b>	05/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/26/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 62-year-old male, with a reported date of injury of 07/30/2014. The diagnoses include shoulder joint derangement, lumbar disc displacement, and cervical disc displacement. Treatments to date have included an MRI of the left shoulder on 04/08/2015; physical therapy; an MRI of the lumbar spine on 12/01/2014; an MRI of the right shoulder on 12/04/2014; electrodiagnostic studies on 11/21/2014; oral medications; and injection into the left shoulder with immediate pain relief. The progress report dated 03/27/2015 indicates that the injured worker had constant pain in the cervical spine, with radiation into the upper extremities and rated 7 out of 10. There was constant pain in the low back, with radiation into the lower extremities, and rated 7 out of 10. There was also constant pain in the bilateral shoulders, rated 8 out of 10. The objective findings include an intact gait, tenderness to palpation of the cervical paravertebral muscle, positive axial loading compression test, limited cervical range of motion with pain, tenderness to palpation of the lumbar paravertebral muscle with spasm, positive seated nerve root test, guarded and restricted lumbar range of motion, tenderness around the anterior glenohumeral region and subacromial space of the left shoulder, positive left impingement sign, painful rotator cuff function, and reproducible symptoms with internal rotation and forward flexion of the shoulder. The medications were refilled on the day of the visit. It was noted that the injured worker benefited from taking the medications. The treating physician requested Eszopiclone 1mg #30, Prevacid 30mg #120, Ondansetron 8mg #30, Cyclobenzaprine Hydrochloride 7.5mg #120, Levofloxacin 750mg #30, and Methoderm Gel 120mg.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Prevacid 30mg (Lansoprazole DR capsules) #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitors Page(s): 68-69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

**Decision rationale:** Based on the 3/27/15 progress report provided by the treating physician, this patient presents with constant cervical pain radiating to the upper extremities rated 7/10 on VAS scale, low back pain radiating into the lower extremities rated 7/10 on VAS scale, and constant bilateral shoulder pain, left > right, rated 8/10 on VAS scale. The treater has asked for Prevacid 30mg (Lansoprazole DR capsules) #120 but the requesting progress report is not included in the provided documentation. The request for authorization was not included in provided reports. The patient received an intra-articular injection on the left shoulder on 3/27/15 with immediate relief. The patient is awaiting authorization for a future right shoulder surgery (unspecified) on 3/27/15 report. The patient is benefiting from his current medication regimen per 3/3/15 report. The patient's work status is "return to modified work with restrictions" but no date is mentioned in 3/3/15 report. MTUS pg 69, NSAIDs, GI symptoms & cardiovascular risk Section states, "Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. 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)." "Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." In this case, the patient is taking Prilosec as of 8/12/14 and 8/29/14 reports. Prevacid is not noted in any reports dated 8/15/14 to 3/27/15. In progress report dated 3/27/15, the treater states that medications are helping in curing and relieving the patient's symptomatology but does not mention a list of current medications. As of 8/29/14, the patient is taking Nabumetone (NSAID) and Prophylactic use of PPI is indicated by MTUS in such cases. However, treater has not provided GI risk assessment for prophylactic use of PPI, as required by MTUS. Provided progress reports do not show evidence of gastric problems, and the patient is under 65 years of age. This request does not meet the criteria enlisted by the guideline. Therefore, the request is not medically necessary.

### **Ondansetron 8mg ODT #30: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (updated 04/30/15) - Online Version.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, under Antiemetics (for opioid nausea).

**Decision rationale:** Based on the 3/27/15 progress report provided by the treating physician, this patient presents with constant cervical pain radiating to the upper extremities rated 7/10 on VAS scale, low back pain radiating into the lower extremities rated 7/10 on VAS scale, and constant bilateral shoulder pain, left > right, rated 8/10 on VAS scale. The treater has asked for Ondansetron 8mg ODT #30 but the requesting progress report is not included in the provided documentation. The request for authorization was not included in provided reports. The patient has headache, dizziness, sensation of "light" with far lateral gaze which are all increasing per 8/29/14 report. The patient received an intra-articular injection on the left shoulder on 3/27/15 with immediate relief. The patient is awaiting authorization for a future right shoulder surgery (unspecified) on 3/27/15 report. The patient is benefiting from his current medication regimen per 3/3/15 report. The patient's work status is "return to modified work with restrictions" but no date is mentioned in 3/3/15 report. MTUS guidelines are silent on antiemetic medications, though ODG Guidelines, Pain (Chronic) Chapter, under Antiemetics (for opioid nausea) states: Not recommended for nausea and vomiting secondary to chronic opioid use. Ondansetron (Zofran): This drug is a serotonin 5-HT<sub>3</sub> receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use. Acute use is FDA-approved for gastroenteritis. The treater does not discuss this request in the reports provided. The 8/29/14 report states that the patient has neurological symptoms due to blunt head trauma (dizziness, visual changes). There is no evidence the patient has had surgery, is undergoing chemotherapy or radiation, or has gastroenteritis, as recommended by ODG and the FDA. The request does not meet guideline indications. Therefore, the requested Ondansetron is not medically necessary.

**Cyclobenzaprine Hydrochloride Tablets 7.5mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

**Decision rationale:** Based on the 3/27/15 progress report provided by the treating physician, this patient presents with constant cervical pain radiating to the upper extremities rated 7/10 on VAS scale, low back pain radiating into the lower extremities rated 7/10 on VAS scale, and constant bilateral shoulder pain, left > right, rated 8/10 on VAS scale. The treater has asked for Cyclobenzaprine Hydrochloride Tablets 7.5mg #120 but the requesting progress report is not included in the provided documentation. The request for authorization was not included in provided reports. The patient received an intra-articular injection on the left shoulder on 3/27/15 with immediate relief. The patient is awaiting authorization for a future right shoulder surgery (unspecified) on 3/27/15 report. The patient is benefiting from his current medication regimen per 3/3/15 report. The patient's work status is "return to modified work with restrictions" but no date is mentioned in 3/3/15 report. MTUS Chronic Pain Guidelines under Muscle relaxants (for pain) pages 63-66 states: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP. The most commonly prescribed antispasmodic agents are Carisoprodol, cyclobenzaprine,

metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy." MTUS, Chronic Pain Medication Guidelines, Muscle Relaxants, page 63-66: "Carisoprodol (Soma, Soprodal 350, Vanadom, generic available): Neither of these formulations is recommended for longer than a 2 to 3 week period." Abuse has been noted for sedative and relaxant effects. Per review of reports, there is no evidence of patient's prior use of Cyclobenzaprine. The UR letter dated 5/8/15 states that "duration of use to date is unclear." MTUS, however, recommends only short-term use of muscle relaxants. This request does not indicate short term-usage as per MTUS guidelines. Therefore, the request is not medically necessary.

**Eszopiclone (Lunesta) 1mg (CIV) #30: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (updated 04/30/15) - Online Version.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental & Stress Chapter states under Eszopicolone (Lunesta).

**Decision rationale:** Based on the 3/27/15 progress report provided by the treating physician, this patient presents with constant cervical pain radiating to the upper extremities rated 7/10 on VAS scale, low back pain radiating into the lower extremities rated 7/10 on VAS scale, and constant bilateral shoulder pain, left > right, rated 8/10 on VAS scale. The treater has asked for Eszopiclone (Lunesta) 1mg (CIV) #30 but the requesting progress report is not included in the provided documentation. The request for authorization was not included in provided reports. The patient received an intra-articular injection on the left shoulder on 3/27/15 with immediate relief. The patient is awaiting authorization for a future right shoulder surgery (unspecified) on 3/27/15 report. The patient is benefiting from his current medication regimen per 3/3/15 report. The patient's work status is "return to modified work with restrictions" but no date is mentioned in 3/3/15 report. ODG-TWC, Mental & Stress Chapter states under Eszopicolone (Lunesta): Not recommended for long-term use, but recommended for short-term use. See Insomnia treatment. See also the Pain Chapter. Recommend limiting use of hypnotics to three weeks maximum in the first two months of injury only, and discourage use in the chronic phase. The FDA has lowered the recommended starting dose of eszopiclone (Lunesta) from 2 mg to 1 mg for both men and women. In this case, there is no mention of patient's prior use of Lunesta in review of reports dated 8/12/14 to 3/27/15. ODG, however, limits the use of hypnotics to "three weeks maximum in the first two months of injury only, and discourage use in the chronic phase." Hence, the request is not medically necessary.

**Levofloxacin 750mg #30: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Infectious Disease (updated 11/11/14) - Online Version.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chapter Infectious diseases under ofloxacin (Levaquin).

**Decision rationale:** Based on the 3/27/15 progress report provided by the treating physician, this patient presents with constant cervical pain radiating to the upper extremities rated 7/10 on VAS scale, low back pain radiating into the lower extremities rated 7/10 on VAS scale, and constant bilateral shoulder pain, left > right, rated 8/10 on VAS scale. The treater has asked for Levofloxacin 750mg #30 but the requesting progress report is not included in the provided documentation. The request for authorization was not included in provided reports. The patient received an intra-articular injection on the left shoulder on 3/27/15 with immediate relief. The patient is awaiting authorization for a future right shoulder surgery (unspecified) on 3/27/15 report. The patient is benefiting from his current medication regimen per 3/3/15 report. The patient's work status is "return to modified work with restrictions" but no date is mentioned in 3/3/15 report. ODG guidelines, chapter 'Infectious diseases' and topic 'Levofloxacin (Levaquin)', states: Recommended as first-line treatment for osteomyelitis, chronic bronchitis, and pneumonia (CAP). The treater does not discuss this request in the reports provided. Review of reports do not show the patient is scheduled for a surgery, or that the patient has osteomyelitis, chronic bronchitis, or pneumonia (CAP). The available medical reports do not provide the information required to make a determination based on ODG guidelines. Hence, the request is not medically necessary.

**Menthoderm Gel 120mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111, 105.

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

**Decision rationale:** Based on the 3/27/15 progress report provided by the treating physician, this patient presents with constant cervical pain radiating to the upper extremities rated 7/10 on VAS scale, low back pain radiating into the lower extremities rated 7/10 on VAS scale, and constant bilateral shoulder pain, left > right, rated 8/10 on VAS scale. The treater has asked for Menthoderm Gel 120mg but the requesting progress report is not included in the provided documentation. The request for authorization was not included in provided reports. The patient received an intra-articular injection on the left shoulder on 3/27/15 with immediate relief. The patient is awaiting authorization for a future right shoulder surgery (unspecified) on 3/27/15 report. The patient is benefiting from his current medication regimen per 3/3/15 report. The patient's work status is "return to modified work with restrictions" but no date is mentioned in 3/3/15 report. Menthoderm gel contains Methyl salicylate and Menthol. MTUS Topical NSAIDs Section page 111 states: "Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." MTUS Pain Outcomes and

Endpoints Section pg 8 states: "When prescribing controlled substances for pain, satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treater does not discuss this request in the reports provided. In regard to the request for Methoderm ointment, review of reports do not show prior use of this topical medication. This medication is indicated for peripheral joint arthritis/tendinitis. The patient does present with upper extremity radiating symptoms, along with neck and shoulder pain. However, there is no documentation as to where it is to be used. Topical NSAIDs would only be indicated for the patient's upper extremity issues but not for other conditions. Topical NSAIDs are not recommended for spinal, shoulder or neuropathic conditions. Given the lack of documentation as to where it is to be utilized, the requested menthoderms gel is not medically necessary.