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| <b>Case Number:</b>   | CM15-0086484 |                              |            |
| <b>Date Assigned:</b> | 05/08/2015   | <b>Date of Injury:</b>       | 09/30/2013 |
| <b>Decision Date:</b> | 06/11/2015   | <b>UR Denial Date:</b>       | 04/24/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/05/2015 |

### 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, 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 55 year old female, who sustained an industrial injury on 9/30/13. She reported initial complaints of neck and mid back pain. The injured worker was diagnosed as having cervical and or lumbar discopathy; cervicgia; carpal tunnel syndrome; double crush syndrome; right shoulder impingement syndrome with labral and rotator cuff tear; left shoulder rotator cuff tear; right hip degenerative joint disease; left knee chondromalacia patella with degenerative tear of the medial/lateral meniscus; right knee meniscus tear with degenerative joint disease; bilateral plantar fasciitis. Treatment to date has included chiropractic therapy; injections (1/8/15 and 2/5/15); medications. Diagnostics included MRI lumbar spine (8/29/14); EMG/NCV lower extremities (9/5/14); x-rays hips, pelvis and coccyx (10/30/14); MRI cervical spine (12/16/14); MRI lumbar spine (12/16/14); bone scan lumbar/pelvis (12/8/14); MRI right knee (2/12/15); MRI left hip (2/12/15); MRI left shoulder (2/12/15); MRI left knee (2/13/15); MRI right shoulder (2/13/15); MRI right hip (2/13/15). Currently, the PR-2 notes dated 3/13/15 indicated the injured worker complains of constant severe pain in the cervical spine that is aggravated by repetitive motions of the neck. The pain is characterized as sharp with radiation to the upper extremities and is associated with headaches that are migrainous in nature as well as tension between the shoulder blades. The pain is documented as an 8/10. There is intermittent pain in both shoulders and characterized as throbbing on a pain scale of 6/10. There is constant severe pain in the low back characterized as sharp radiating to the lower extremities with a pain scale of 8/10. She is having increasing difficulty with sleep due to pain levels. The provider notes constant pain in the bilateral hips characterized as sharp/stabbing on a pain scale of 7/10. She has

frequent pain in both knees and the injured worker reports with some swelling and instability and a pain level of 7/10. She also reports bilateral intermittent feet pain as sharp/burning on a pain scale of 6/10. Her treatment plan includes recommendation of a lumbar epidural steroid injection, bilateral knee braces (she uses a cane at this time for walking). The provider has requested medications: Ondansetron 8 MG #30, Cyclobenzaprine Hydrochloride 7.5 MG #120 and Tramadol 150 MG #90.

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

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

#### **Ondansetron 8 MG #30: Upheld**

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

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

**Decision rationale:** Regarding the request for ondansetron (Zofran), California MTUS guidelines do not contain criteria regarding the use of antiemetic medication. ODG states that antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. Guidelines go on to recommend that ondansetron is approved for postoperative use, nausea and vomiting secondary to chemotherapy, and acute use for gastroenteritis. Within the documentation available for review, there is no indication that the patient has nausea as a result of any of these diagnoses. In the absence of clarity regarding those issues, the currently requested ondansetron (Zofran) is not medically necessary.

#### **Cyclobenzaprine Hydrochloride 7.5 MG #120: Upheld**

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

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

**Decision rationale:** Regarding the request for cyclobenzaprine, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested cyclobenzaprine is not medically necessary.

#### **Tramadol 150 MG #90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Medications Page(s): 75-80.

**Decision rationale:** Regarding the request for Tramadol, Chronic Pain Medical Treatment Guidelines state that Tramadol is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, the patient is prescribed 3 different shot acting narcotic medications, including Tramadol, Norco, and Tylenol #3, without clear documentation of improvement in pain or functionality. There is no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Tramadol is not medically necessary.