

<b>Case Number:</b>	CM15-0087358		
<b>Date Assigned:</b>	05/11/2015	<b>Date of Injury:</b>	09/02/2009
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	04/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/06/2015

### 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: Florida

Certification(s)/Specialty: Family Practice

### 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 59 year old female, who sustained an industrial injury on 09/02/2009. She has reported subsequent neck and low back pain and was diagnosed with multiple herniated nucleus pulposus of the lumbar spine with stenosis and neural foraminal narrowing, degenerative disc disease of the lumbar and cervical spine, herniated nucleus pulposus of the cervical spine with canal stenosis, multiple osteophytes of the cervical spine, bilateral hip arthralgia and right hip trochanteric bursitis. Treatment to date has included oral and topical pain medication, chiropractic therapy and aquatic therapy. In a progress note dated 03/16/2015, the injured worker complained of neck and back pain. Objective findings were notable for a severely antalgic and slow gait, tenderness of the right hip, diffuse tenderness to palpation of the cervical spine, trapezius, thoracic and lumbar paraspinal muscles, spasms of the cervical and lumbar spine with decreased range of motion, hypersensitivity of the left C6-C8 dermatomes and decreased right L4-L5 dermatomes to pinprick and light touch. A request for authorization of home health care nurse/aid 2x/week for 3 hours each visit (unspecified number of sessions), pharmacy purchase of Lidopro topical ointment #1, Ondansetron, Cyclobenzaprine and Medrox patches #5 was submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home health care nurse aid 2 times a week for 3 hours each visit (unspecified number of sessions): 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), Low back chapter, Home Health Services.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 85.

**Decision rationale:** MTUS guidelines states regarding home health care services: "Recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or 'intermittent' basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. (CMS, 2004)" Utilization review partially certified this request for 1 month of home health care services as the patient has substantial limitations secondary to her prior injuries. Utilization review did not fully certify the request due to a lack of documentation regarding duration of treatment, and lack of a detailed treatment plan on the part of the treating physician. This is a reasonable decision on the part of utilization review. Likewise, this request as it currently stands (with no duration of treatment noted) is not medically necessary.

**Pharmacy purchase of Lidopro topical ointment #1: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56-57.

**Decision rationale:** In accordance with California Chronic Pain MTUS guidelines, Lidoderm (topical Lidocaine) may be recommended for localized peripheral pain after there has been a trial of a first-line treatment. The MTUS guideline specifies tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica as first line treatments. The provided documentation does not show that this patient was tried and failed on any of these recommended first line treatments. Topical Lidocaine is not considered a first line treatment and is currently only FDA approved for the treatment of post-herpetic neuralgia. Likewise, for the aforementioned reasons, the requested topical Lidopro is not medically necessary.

**Ondansetron 4mg #10: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 2015 ODG Online edition. Ondansetron.

**Decision rationale:** The California MTUS guidelines do not address the usage of Ondansetron. Likewise, the ODG guidelines were utilized in making this determination. The ODG guidelines state that Zofran is FDA approved for gastroenteritis, chemotherapy and radiation induced nausea and vomiting, and in the immediate postoperative period. Records do not indicate that this patient has any of the aforementioned conditions. Likewise, this request for Zofran is not medically necessary.

**Cyclobenzaprine 7.5mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-spasticity/Antispasmodic Drugs, page(s) 100, 97 Page(s): 100, 97.

**Decision rationale:** In accordance with the California MTUS guidelines, Cyclobenzaprine is a muscle relaxant and muscle relaxants are not recommended for the treatment of chronic pain. From the MTUS guidelines: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP". Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Likewise, this request for Cyclobenzaprine is not medically necessary.

**Medrox patches #5 patches:** 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 rationale:** In accordance with California MTUS guidelines, topical analgesics are considered "Largely experimental in use with few randomized controlled trials to determine efficacy or safety." Guidelines go on to state that, "There is little to no research to support the use of many of these agents." The guideline specifically says, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The requested topical analgesic Medrox contains Methylsalicylate, which is an NSAID. MTUS guidelines specifically state regarding topical "Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." Likewise, the requested medication is not medically necessary.