

<b>Case Number:</b>	CM14-0117056		
<b>Date Assigned:</b>	09/23/2014	<b>Date of Injury:</b>	05/10/2011
<b>Decision Date:</b>	12/31/2014	<b>UR Denial Date:</b>	07/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2014

### 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. The expert reviewer is Board Certified in Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 63 year old patient with date of injury of 05/10/2011. Medical records indicate the patient is undergoing treatment for overuse syndrome of bilateral upper extremity, internal derangement of right shoulder, right shoulder tendinitis, bilateral elbow medial epicondylitis, bilateral elbow cubital tunnel syndrome, bilateral wrist carpal tunnel syndrome, bilateral de Quervain's tendinitis, trigger of the 2nd, 3rd, 4th and 5th fingers bilaterally, Klenbock's disease of the right wrist, musculoligamentous sprain of the lumbar spine with lower extremity radiculitis, disc protrusion of L3-4 and L5-S1, disc bulge L4-L5 and spondylolisthesis L5-S1. Subjective complaints include pain 7-8/10 reduced to a 6/10 with medications; low back pain, described as constant radiating to the right leg and foot, numbness to right foot, right shoulder pain, clicking and limited range of motion, pain to both elbows with lifting, pressure or touch, pain and cracking in both wrists and numbness to both hands which is greater at night. Objective findings include patient lacks toe touch by 9 inches and tenderness over posterior superior iliac spines, bilaterally. Treatment has consisted of acupuncture, MRI of lumbar spine, chiropractic therapy, Methocarbamol, Tramadol, Flurbiprofen/Lidocaine and Flurbiprofen. The utilization review determination was rendered on 07/07/2014 recommending non-certification of Methocarbamol 750mg #90 refills 3 and Momestason/doxepin 0.15%/5%/60gm.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Methocarbamol 750mg #90 refills 3: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** MTUS states regarding muscle relaxants, "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP" and ". . . they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence." Methocarbamol is a second line agent for short term treatment of acute muscle spasms. The medical records indicate that Methocarbamol has been prescribed in excess of guideline recommendations. Medical documents also do not indicate what first-line options were attempted and the results of such treatments. Additionally, records do not indicate functional improvement with the use of this medication or other extenuating circumstances, which is necessary for medication usage in excess of guidelines recommendations. As such, the request for Methocarbamol 750mg #90 refills 3 is not medically necessary.

**Momestasonedoxepin 0.15%/5%/60gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Compounding Medications Page(s): 71.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 113.

**Decision rationale:** MTUS and ODG recommend usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." There is no indication the claimant has neuropathic pain and has tried and failed other medications. As such the request for Momestasonedoxepin 0.15%/5%/60gm is not medically necessary.