

<b>Case Number:</b>	CM14-0148197		
<b>Date Assigned:</b>	09/18/2014	<b>Date of Injury:</b>	04/05/2013
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	08/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2014

### 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 Family Medicine and is licensed to practice in California. 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 57-year-old male with a 4/5/13 date of injury. The patient developed a continuous trauma injury to his shoulders and back throughout his career as a deputy sheriff/██████████. According to a progress report dated 4/29/13, the patient complained of intermittent pain in the low back and both shoulders. The pain was aggravated by bending, lifting, reaching, and prolonged sitting and standing. Cyclobenzaprine was prescribed for the palpable paravertebral muscle spasms noted in the cervical and lumbar spine. Ondansetron was prescribed as needed for nausea associated with the Cyclobenzaprine which the patient was given for his muscle spasms. Objective findings noted were pain and tenderness in the anterior glenohumeral region and subacromial space, pain and tenderness in the mid to distal lumbar segments, paravertebral muscle spasm, restricted range of motion of lumbar spine, and L4-5 and L5-S1 dysesthesia in lower extremities. Diagnostic impression was listed as cervical/lumbar discopathy, rule out internal derangement bilateral shoulders. Treatment to date has consisted of medication management and activity modification. A UR decision dated 8/18/14 denied the requests for Tramadol ER, Ondansetron, and Medrox and modified the request for Cyclobenzaprine from 120 tablets to 20 tablets.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cyclobenzaprine 7.5mg #120, date of service (DOS) 04/29/13: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), TWC Pain Procedure Summary

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41-42.

**Decision rationale:** According to page 41 of the California MTUS Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine is recommended as an option, using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. There is also a post-operative use. The addition of cyclobenzaprine to other agents is not recommended. It is unclear how long the patient has been taking Cyclobenzaprine. The UR decision dated 8/18/14 modified this request to certify 20 tablets, as 120 tablets is excessive since guidelines do not support the long-term use of muscle relaxants. In addition, there is no documentation that the patient has had an acute exacerbation to his pain. Therefore, the request for Cyclobenzaprine 7.5mg #120, DOS: 04/29/13, was not medically necessary.

**Tramadol ER 150mg, #90, DOS: 04/29/13: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain and Criteria for use for a therapeutic tr.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. This is a recent injury, and it is unclear how long the patient has been taking Tramadol. There is no discussion regarding non-opiate means of pain control, or endpoints of treatment. There is no rationale provided as to why the patient requires an opioid medication for pain control at this time. Therefore, the request for Tramadol ER 150mg, #90, DOS: 04/29/13 was not medically necessary.

**Ondansetron ODT 8mg #30, DOS: 04/29/13: 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), TWC Pain Procedure Summary, Anti-emetics (for opioid nausea)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA (Ondansetron)

**Decision rationale:** The California MTUS and ODG do not address this issue. The FDA states that Ondansetron is indicated for prevention of nausea and vomiting caused by cancer chemotherapy, radiation therapy and surgery. In the reports reviewed, there is no documentation that the patient has complaints of nausea and/or vomiting. In addition, it is noted that Ondansetron was prescribed for prophylaxis from nausea associated with Cyclobenzaprine. Guidelines do not support the use of Ondansetron for prophylactic purposes to protect from side effects of medications. There is no documentation that the patient has had cancer, chemotherapy, radiation therapy, or surgery. Therefore, the request for Ondansetron ODT 8mg #30, DOS: 04/29/13 was not medically necessary.

**Medrox 120gm x2, DOS: 04/29/13: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**Decision rationale:** Regarding Medrox, a search of online resources identifies Medrox ointment to be a compounded medication that includes 0.0375% Capsaicin, 20% Menthol, and 5% Methyl Salicylate. The California MTUS Chronic Pain Medical Treatment Guidelines state that Ketoprofen, Lidocaine (in creams, lotion or gels), Capsaicin in a 0.0375% formulation, Baclofen and other muscle relaxants, and Gabapentin and other anti-epilepsy drugs are not recommended for topical application. There is no clear rationale for using this medication as opposed to alternatives supported by evidence-based guidelines. Therefore, the request for Medrox 120gm x2, DOS: 4/29/13 was not medically necessary.