

Case Number:	CM13-0025597		
Date Assigned:	11/20/2013	Date of Injury:	03/22/2000
Decision Date:	08/01/2014	UR Denial Date:	08/30/2013
Priority:	Standard	Application Received:	09/18/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in New York and Texas. 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:

The injured worker is a 62 year old female injured on 03/22/00 due to an undisclosed mechanism of injury. The current diagnoses include medial epicondylitis of the right elbow, bursitis/tenosynovitis of the right shoulder, status post right shoulder arthroscopy, subacromial decompression, acromioclavicular joint resection, cervical strain with multi-level disc protrusions, degenerative disc disease of the cervical spine, lumbar strain with multi-level disc protrusions, degenerative disc disease in the lumbar spine, right ankle strain, right hip greater trochanteric bursitis, and radiculitis of the bilateral lower extremities. The documentation indicates the injured worker continues to complain of moderate to severe lower back pain rated at 6-7/10 as well as neck and right ankle pain. It is noted the medications give the injured worker some functional improvement and pain relief. Physical assessment reveals positive Spurling's test to the right shoulder, positive tenderness over the paracervical musculature, negative muscle spasms in the paracervical musculature, motor testing 5/5 to the bilateral upper extremities, decreased range of motion in the cervical spine, positive tenderness in the paralumbar musculature, positive muscle spasms in the paralumbar musculature, motor testing 5/5 to the bilateral lower extremities, the inability to walk on toes and heels secondary to pain, deep tendon reflexes 2+ to the bilateral lower extremities, lumbar range of motion decreased, negative straight leg raise negative bilaterally, and positive greater tuberosity tenderness. The injured worker was prescribed Cyclobenzaprine 7.5mg, Diclofenac 100mg daily, Omeprazole 20mg, Ondansetron 4mg daily, and Tramadol 150mg daily. The initial request for Flexeril 20mg, Ondansetron 4mg, Ultram ER 150mg, quantity unknown, and physical therapy 3 x per week for 6 weeks was initially non-certified on 08/30/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF FLEXERIL 20MG, (QUANTITY UNKNOWN): 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 9792.20, CYCLOBENZAPRINE Page(s): 41.

Decision rationale: As noted on page 41 of the Chronic Pain Medical Treatment Guidelines, cyclobenzaprine is recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Documentation indicates the presence of paralumbar spasm which would be indicative of the need for muscle relaxants; however, the request failed to provide a frequency, quantity, and number of refills. As such, the medical necessity of prescription of Flexeril 20mg, (quantity unknown) cannot be established at this time.

PRESCRIPTION OF ONDANSETRON 4MG, (QUANTITY UNKNOWN): Upheld

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

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), ANTIEMETICS (FOR OPIOID NAUSEA).

Decision rationale: As noted in the Pain chapter of the Official Disability Guidelines, antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. Zofran is Food and Drug Administration FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use and acute gastroenteritis. There is no documentation of previous issues with nausea or an acute diagnosis of gastroenteritis. Additionally, if prescribed for post-operative prophylaxis, there is no indication that the injured worker has previously suffered from severe post-operative nausea and vomiting. Additionally, the medication should be prescribed once an issue with nausea and vomiting is identified, not on a prophylactic basis. Further, the request did not provide the frequency, quantity, and number of refills. As such, the request for prescription of ondansetron 4mg, (quantity unknown) cannot be recommended as medically necessary.

PHYSICAL THERAPY THREE TIMES PER WEEK FOR SIX WEEKS (BODY PART UNKNOWN): 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 9792.20, PHYSICAL MEDICINE Page(s): 98.

Decision rationale: As noted on page 98 of the Chronic Pain Medical Treatment Guidelines, indicate that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. There is no documentation of exceptional factors specific to one body area that would support the need for therapy that exceeds guidelines either in duration of treatment or number of visits. The request does not specify a body part to be addressed during physical therapy. As such, the medical necessity of the physical therapy three times per week for six weeks (body part unknown) cannot be established at this time.

PRESCRIPTION OF ULTRAM ER 150MG, (QUANTITY UNKNOWN): 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 CRITERIA FOR USE OF OPIOIDS Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. In addition, no recent opioid risk assessments regarding possible dependence or diversion were available for review. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of prescription of Ultram ER 150mg, (quantity unknown) cannot be established at this time.