MAXIMUS Federal Services

Case Number:	CM13-0029187		
Date Assigned:	03/17/2014	Date of Injury:	06/03/2010
Decision Date:	05/08/2014	UR Denial Date:	06/16/2013
Priority:	Standard	Application Received:	09/24/2013

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, 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:

The injured worker was seen on August 14, 2012 with complaint of continued low back pain with extension into the right lower extremity. Objective findings the physician noted lumbar spine reveals some symptomatology in the lumbar spine with extension into the right lower extremity. On April 2, 2012, the injured worker saw a different doctor for a second opinion consult. It was noted in part of the medical record review that the injured worker has had an epidural injection, and [redacted] has recommended lumbar surgery. The injured worker describes popping sensation with soreness, stiffness, and sharp pain. There is radiation into the right lower extremity. The physician noted severe lumbar discopathy/radiculitis and herniated nucleus pulposus. The patient did have an MRI, date not noted, showing a 5 mm protrusion along with foraminal involvement. Updated MRI showed a 5 to 6 central and right paracentral extrusion with an annular abnormality. The injured worker had right sided radiation with radicular involvement along with an MRI that did correlate. The treatment being requested is Omeprazole 20mg/cap #120, Ondansentron ODT 4mg/tab #30, and Cyclobenzaprine Hydrochloride 7.5mg/tab #120. The date and rationale for the requested treatment was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

OMEPRAZOLE 20MG/CAP #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68 - 69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: The injured worker is a 45-year-old with diagnoses of severe lumbar discopathy/radiculitis, and herniated nucleus pulposus. The California Guidelines states for NSAIDs (non-steroidal anti-inflammatory drugs) the physician should determine if the injured worker is at risk for gastrointestinal events if they are over 65 years of age, have a history of peptic ulcer, GI (gastrointestinal) bleeding or perforation, concurrent use of aspirin, corticosteroids, and/or anticoagulant. The documentation provided for review does not reveal the patient had any of the indicated risk factors to meet guideline criteria. The request which was submitted failed to include the frequency of the medication in order to determine necessity. The request for omeprazole 20mg/cap, 120 count, is not medically necessary or appropriate.

ONDANSETRON ODT 4MG/TAB #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN, ANTIEMETICS.

Decision rationale: The request for ondansetron ODT 4mg/tab #30 is non-certified. The injured worker is a 45-year-old male with diagnoses of severe lumbar discopathy/radiculitis, and herniated nucleus pulposus. The Official Disability Guidelines state Odansetron is under the anti-emetics for opioid nausea. It is not recommended for nausea and vomiting secondary to chronic opioid use. Per the Guidelines, this is not recommended. There also is no documentation that the injured has any complains of GI distress. Also, the request as submitted failed to provide the frequency. The request for ondansetron ODT 4mg/tab, thirty count, is not medically necessary or appropriate

CYCLOBENZAPRINE HYDROCHLORIDE 7.5MG/TAB #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

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

Decision rationale: The request for cyclobenzaprine hydrochloride 7.5mg/tab #120 is non-certified. The injured worker is a 45-year-old male with diagnoses of severe lumbar discopathy/radiculitis, and herniated nucleus pulposus. The documentation provided did note that the injured worker was seen for continued low back pain with extension into the right lower extremity. Objective findings from the August 14, 2012 office note noted physical examination of the lumbar spine residual symptomatology in the lumbar spine with extension into the right

lower extremity. The injured worker has had an MRI that showed a 5 to 6 mm central and right paracentral extrusion with an annular abnormality. The injured worker clearly has right sided radiation with radicular involvement along with an MRI that did correlate. California Guidelines states that cyclobenzaprine is recommended as an option using a short course of therapy. The effect is greatest in the first four days of treatment, suggesting that shorter course may be better. The treatment should be brief. The most recent note submitted was dated August 14, 2012. The clinical information submitted did not indicate the length of time the patient has been taking this medication and it is only recommended for short term, the request as submitted is not supported. The frequency of the medications was not provided in the request as submitted. The request for cyclobenzaprine hydrochloride 7.5mg/tab, 120 count, is not medically necessary or appropriate.