

Case Number:	CM13-0030640		
Date Assigned:	06/06/2014	Date of Injury:	04/30/2011
Decision Date:	07/14/2014	UR Denial Date:	09/18/2013
Priority:	Standard	Application Received:	09/30/2013

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 Sports Medicine, and is licensed to practice in 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 51-year-old male with a reported date of injury of 04/30/2011. The mechanism of injury was not provided within the documentation available for review. The injured worker presented with complaints of neck pain radiating to the right pectoralis and right shoulder blade. The physician indicated the injured worker participated in physical therapy in 05/2012. In 09/2012, the injured worker underwent a C5-7 anterior cervical fusion. Within the documentation dated 04/04/2013, the physician indicated the injured worker participated in additional physical therapy; the results of which were not provide within the clinical information provided. . The injured worker's neck pain was rated 4/10 to 8/10. Upon physical examination, the injured worker's cervical spine range of motion revealed flexion to 40 degrees, extension to 15 degrees, lateral bend to 15 degrees bilaterally, and rotation to 65 degrees on the right and to 70 degrees on the left. The injured worker's diagnosis included cervical myofascial sprain/strain, cervical herniated nucleus pulposus, cervical stenosis, cervical radiculopathy, 2 level cervical fusion, thoracic spine degenerative disc disease, lumbar myofascial sprain/strain, lumbar disc disease, and lumbar facet arthropathy. The injured worker's medication regimen included Naproxen, Tylenol and Omeprazole. The retrospective request for Omeprazole DR 20 mg, quantity 120, date of service 07/17/2013; decision for retrospective request for Ondansetron ODT 8 mg, quantity 60, date of service 07/17/2013; and retrospective request for Tramadol HCL ER 150 mg, quantity 90, date of service 07/17/2013 was submitted on 09/28/2013. Rationale for the request was not provided within the clinical information available for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR OMEPRAZOLE DR 20 MG, QTY: 120 DATE OF SERVICE 07/17/2013: 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.

Decision rationale: NSAIDS are recommended with precaution if the injured worker is at risk for gastrointestinal events. The criteria to determine risk for gastrointestinal events would include: greater than 65 years old, history of peptic ulcer, GI bleeding, or perforation, concurrent use of aspirin, corticosteroids, and/or anticoagulant or high dose multiple NSAID use. The guidelines recommend that injured workers with high risk of gastrointestinal events with no cardiovascular disease utilize a selective agent plus a PPI if absolutely necessary. The clinical information provided for review lacks documentation of the therapeutic use or goal of Omeprazole. There is a lack of documentation related to gastrointestinal upset or complaints. In addition, the request as submitted failed to provide frequency and directions for use. Therefore, the retrospective request for Omeprazole DR 20 mg, quantity 120, date of service 07/27/2013 is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR ONDANSETRON ODT 8 MG, QTY: 60 DATE OF SERVICE 07/17/2013: 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, Antiemetic.

Decision rationale: The Official Disability Guidelines do not recommend antiemetics for nausea and vomiting secondary to chronic opioid use. If nausea and vomiting remained prolonged, other etiologies of these symptoms should be evaluated. In addition, Zofran is FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment. Acute use is FDA approved for gastroenteritis. There is a lack of documentation related to therapeutic effect of Ondansetron ODT. In addition, the rationale for the request was not provided within the documentation available for review. The request as submitted failed to provide frequency and directions for use. There is a lack of documentation included in the clinical information related to nausea, vomiting, chemotherapy, radiation therapy or other approved use for antiemetics. Therefore, the retrospective request for Ondansetron ODT 8 mg, quantity 60, date of service 07/17/2013 is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR TRAMADOL HCL ER 150 MG, QTY: 90 DATE OF SERVICE 07/17/2013: 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 Opioids, On-going Management Page(s): 78.

Decision rationale: According to the California MTUS Guidelines, the ongoing management of opioid use should include the lowest possible dose to be prescribed to include pain and function. In addition, continued opioid use should include on-going review and documentation of pain relief, functional status, appropriate medication use, and side effects. The satisfactory response to treatment may be indicated by the injured worker's decreased pain, increased level of function, or improved quality of life. The injured worker's medication regimen was not provided within the documentation available for review and in addition a rationale for the request was not provided within the clinical information. There is a lack of documentation related to the injured worker's functional deficits and the therapeutic effect of the use of Tramadol. In addition, the request as submitted failed to provide frequency and directions for use for Tramadol. Therefore, the retrospective request for Tramadol HCL ER 150 mg, quantity 90, date of service 07/17/2013 is not medically necessary and appropriate.