

<b>Case Number:</b>	CM13-0034625		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	12/05/2007
<b>Decision Date:</b>	12/15/2014	<b>UR Denial Date:</b>	10/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/16/2013

### 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 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 60 year old female injured on 12/05/07 due to undisclosed mechanism of injury. Neither the specific injury sustained nor the initial treatments rendered were addressed in the clinical documentation submitted for review. The injured worker underwent lumbar stabilization and decompressive procedure including L4-S1 posterior lumbar interbody fusion following the initial injury. The injured worker reported improvement in overall symptomology including lower extremities radicular pain following surgical intervention. Prior utilization review indicated physical examination on 10/23/13 revealed tenderness over the spinal hardware with both deep and superficial palpation. Additional clinical documentation was not submitted for review. Initial request was denied on 10/03/13.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ONDANSETRON ODT TABLETS; 4 OR 8MG #60:** 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 FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use and acute gastroenteritis. There were no recent clinical documents submitted for review. The lack of documentation limits the ability to establish the injured worker's current status and substantiate the medical necessity of the requested medication. As such, the request for ondansetron ODT tablets; 4 OR 8MG #60 is not medically necessary and appropriate.

**CYCLOBENZAPRINE HYDROCHLORIDE TABLETS 7.5MG, #120: Upheld**

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

**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. There were no recent clinical documents submitted for review. The lack of documentation limits the ability to establish the injured worker's current status and substantiate the medical necessity of the requested medication. As such, the medical necessity of cyclobenzaprine hydrochloride tablets 7.5MG, #120 cannot be established at this time. The request is not medically necessary and appropriate.

**TRAMADOL HYDROCHLORIDE ER #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 94-95.

**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 were no recent clinical documents submitted for review. The lack of documentation limits the ability to establish the injured worker's current status and substantiate the medical necessity of the requested medication. As such, Tramadol Hydrochloride ER #90 is not medically necessary and appropriate.

**ALPRAZOLAM EXTENDED-RELEASE TABLETS 1MG #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Benzodiazepines Page(s): 24.

**Decision rationale:** As noted on page 24 of the Chronic Pain Medical Treatment Guidelines, Benzodiazepines are not recommended for long-term use due to lack of proven efficacy with prolonged use and the risk of dependence. Most guidelines limit use to 4 weeks. Chronic Benzodiazepines are the treatment of choice in very few conditions. There were no recent clinical documents submitted for review. The lack of documentation limits the ability to establish the injured worker's current status and substantiate the medical necessity of the requested medication. As such, the request for Alprazolam extended-release tablets 1MG #60 is not medically necessary and appropriate.