

<b>Case Number:</b>	CM13-0036939		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	01/26/2011
<b>Decision Date:</b>	02/20/2014	<b>UR Denial Date:</b>	09/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/22/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Cardiology, was Fellowship trained in Cardiovascular Disease, 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 physician 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 patient is a 57-year-old male who reported an injury on 1/26/11. The mechanism of injury was not provided in the medical record. Clinical documentation from 9/12/13 reported that the patient complained of persistent pain of the neck that was aggravated by repetitive motions of the neck, and prolonged positioning of the neck. The pain was also aggravated with pushing, pulling, lifting, forward reaching, and working at or above shoulder level. The patient states that the pain is in bilateral shoulders. He also complains of low back pain that is aggravated by bending, twisting, pushing, lifting, pulling, sitting, standing, and walking multiple blocks. He also has left elbow pain. Physical examination of the cervical spine revealed tenderness at the cervical paravertebral muscle, and upper trapezius muscle with spasms. There is also pain and restricted cervical spine range of motion noted. There was positive impingement, Hawkins signs, and pain with terminal motion noted to bilateral shoulders. The patient continued to have pain to bilateral wrists, and his grip was weakened. Physical examination of the lumbar spine noted tenderness from the mid to distal lumbar segments and there is pain with terminal motion. The patient was preoperative for right carpal tunnel release procedure.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**120 Omeprazole delayed release 20mg: 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 Page(s): 68-69.

**Decision rationale:** Per the California MTUS guidelines, the requested medication is recommended for patients that are at risk for gastrointestinal problems. The patient is not over the age of 65, does not have a history of peptic ulcers or GI bleeds, is not currently receiving any aspirin, corticosteroids, or receiving any anticoagulants. As such, the request is non-certified.

**60 Ondansetron ODT 4 or 8mg:** 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

**Decision rationale:** The California MTUS/ACOEM does not address antiemetics or Ondansetron. The Official Disability Guidelines state that Ondansetron (Zofran) is not recommended for nausea and vomiting secondary to chronic opioid use. As such, there is no documentation provided in the medical record that the patient was experiencing any nausea or vomiting prior to the use of his current or previous medication regimen. Therefore, the request is non-certified.

**90 Tramadol Hydrochloride ER 150mg:** 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 Page(s): 75, 78-79.

**Decision rationale:** Per California MTUS the requested medication is classified as an opioid, and with ongoing management with opioids, there are several requested guidelines that must be followed. These include the lowest possible dose should be prescribed to improve the pain and function; there should be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There was no current clinical documentation of any pain assessments being done by the patient or for the patient. There is no current clinical documentation of the patient's pain level pre or post taking the medication. There is no documentation of the patient's change in functional status. As such, the medical necessity for the requested medication cannot be proven. Therefore, the request is non-certified.