

Case Number:	CM13-0038044		
Date Assigned:	12/18/2013	Date of Injury:	03/16/2013
Decision Date:	04/28/2014	UR Denial Date:	09/19/2013
Priority:	Standard	Application Received:	10/24/2013

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 Family Practice 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 patient is a 30-year-old male who reported an injury on 03/16/2013. The mechanism of injury was not stated. The patient is diagnosed with lumbar discopathy with radiculitis. The patient was seen on 08/21/2013. The patient reported persistent symptomatology in the lumbar spine. Physical examination on that date revealed pain and tenderness to palpation of the lumbar spine with positive straight leg raising and weakness in the right lower extremity. It is noted that the patient underwent electrodiagnostic studies on 08/08/2013, which indicated no evidence of entrapment neuropathy on the peroneal and tibial nerves as well as no evidence of peripheral neuropathy in the lower extremities. Treatment recommendations at that time included a lumbar epidural block as well as continuation of current medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF NAPROXEN 550MG #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line treatment after acetaminophen. There is no evidence of long-term effectiveness for pain or function. The patient has utilized naproxen sodium 550 mg since 07/2013. There was no evidence of objective functional improvement as a result of the ongoing use of this medication. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.

PRESCRIPTION OF CYCLOBENZAPRINE 7.5MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (For Pain)..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as no sedating second line options for short-term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. There was no evidence of palpable muscle spasm or spasticity upon physical examination. Guidelines do not recommend long-term use of this medication. Therefore, the request cannot be determined as medically appropriate. As such, the request is non-certified.

PRESCRIPTION OF ONDANSETRON 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), Chronic Pain Chapter, Ondansetron, Antiemetics.

Decision rationale: Official Disability Guidelines state Zofran is not recommended for nausea and vomiting secondary to chronic opioid use. Zofran has been FDA approved for nausea and vomiting secondary to chemotherapy and radiation as well as postoperative use. The patient does not meet any of the abovementioned criteria as outlined by the Official Disability Guidelines. Therefore, the request is non-certified.

PRESCRIPTION OF OMEPRAZOLE 20MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nsaids, Gi Symptoms & Cardiovascular Risk..

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

Decision rationale: California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. There is no indication of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the requested medication. As such, the request is non-certified.

PRESCRIPTION OF TRAMADOL ER 150MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of no opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the patient has utilized Tramadol ER 150 mg since at least 07/2013. There is no evidence of objective functional improvement as a result of the ongoing use of this medication. Satisfactory response to treatment has not been indicated by a decrease in pain level, increase in function, or improved quality of life. Therefore, the request is non-certified.

PRESCRIPTION OF QUAZEPAM USP 15MG #30: Upheld

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

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

Decision rationale: California MTUS Guidelines state benzodiazepines are not recommended for long-term use, because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit the use to 4 weeks. There is no evidence of an anxiety disorder. There is also no evidence of chronic insomnia. The medical necessity for the requested medication has not been established. As guidelines do not recommend long-term use of this medication, the current request cannot be determined as medically appropriate. As such, the request is non-certified.

PRESCRIPTION OF MEDROX PATCHES #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. There is no evidence of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. Therefore, the request cannot be determined as medically appropriate. As such, the request is non-certified.