

Case Number:	CM13-0038050		
Date Assigned:	12/18/2013	Date of Injury:	04/03/2006
Decision Date:	05/30/2014	UR Denial Date:	09/20/2013
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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 patient is a 41 year-old male who is reported to have sustained work related injuries on 04/03/06. It is reported that the patient developed cervical pain with radiation into the upper extremities secondary to the chronic use of a vest that was too small. Records indicate the patient failed conservative management and was ultimately taken to surgery in 12/2012. At this time the patient underwent C3/4 and C5/6 hybrid construction. Post-operatively, the patient is reported to be improved. The most recent detailed clinical note is 05/30/13. The patient reports headaches and nausea not relieved by Prilosec. He further reports and upset stomach when taking Naproxen. Physical examination is reported to show some residual symptoms. On 09/12/13, the patient was seen in follow-up. No detailed information was provided and prescriptions were refilled. A utilization review report dated 9/20/13 recommended non-certification of Naproxen, Omeprazole, Ondansetron, Tramadol, and Alprazolam. Cyclobenzaprine was modified from 120 to 63.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR NAPROXEN SODIUM 550MG, #120 DOS: 8/20/13:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-73.

Decision rationale: Regarding the retrospective request for Naproxen Sodium 550mg, #120 DOS: 8/20/13, Chronic Pain Medical Treatment Guidelines state that (NSAIDs) non-steroidal anti-inflammatory drugs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no documentation indicating that, during the time period under review, Naproxen was providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale) or any objective functional improvement. In the absence of such documentation, the retrospective request for Naproxen Sodium 550mg, #120 dos: 8/20/13 is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR OMEPRAZOLE 20MG, #120 DOS: 8/20/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS AND CARDIOVASCULAR RISK.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69 of 127.

Decision rationale: Regarding the retrospective request for Omeprazole 20mg, #120 dos: 8/20/13, Chronic Pain Medical Treatment Guidelines states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to (NSAIDs) non-steroidal anti-inflammatory drugs therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no documentation indicating that, during the time period under review, the patient had complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the retrospective request for Omeprazole 20mg, #120 dos: 8/20/13 is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR ONDANSETRON 8MG, #60 DOS: 8/20/13: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG): PAIN CHAPTER, ONDANSETRON (ZOFRAN_i ½) AND ANTIEMETICS (FOR OPIOID NAUSEA).

Decision rationale: Regarding the retrospective request for Ondansetron 8mg, #60 dos: 8/20/13, California MTUS does not address this medication. ODG states that it is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment, postoperative nausea, and gastroenteritis. Within the documentation available for review, there is no documentation indicating that, during the time period under review, the patient had any nausea and/or vomiting

secondary to a supported indication as noted above. In the absence of such documentation, the retrospective request for Ondansetron 8mg, #60 dos: 8/20/13 is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR CYCLOBENZAPRINE 7.5MG, #120 DOS: 8/20/13:
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: Regarding the retrospective request for Cyclobenzaprine 7.5mg, #120 DOS: 8/20/13, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no documentation indicating that, during the time period under review, there was a specific analgesic benefit or objective functional improvement as a result of the Cyclobenzaprine. Additionally, it does not appear that this medication was being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the retrospective request for Cyclobenzaprine 7.5mg, #120 DOS: 8/20/13 is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR TRAMADOL HYDROCHLORIDE ER 150MG, #90 DOS: 8/20/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRAMADOL (Ultram).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-80.

Decision rationale: Regarding the retrospective request for Tramadol Hydrochloride ER 150mg, #90 DOS: 8/20/13, Chronic Pain Medical Treatment Guidelines state that, due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no documentation indicating that, during the time period under review, the medication was improving the patient's function or pain (in terms of percent reduction in pain or reduced NRS). There was also no documentation regarding side effects, aberrant use, or monitoring for compliance. Opioids should not be abruptly discontinued; however, unfortunately, there is no provision for modification of the request. In light of the above issues the retrospective request for Tramadol Hydrochloride ER150mg, #90 DOS: 8/20/13 is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR ALPRAZOLAM 1MG, #60 DOS: 8/20/13: Upheld

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

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

Decision rationale: Regarding the retrospective request for Alprazolam 1mg, #60 DOS: 8/20/13, Chronic Pain Medical Treatment Guidelines state that benzodiazepines are "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant." Within the documentation available for review, there is no documentation indicating that, during the time period under review, the medication was providing any significant functional improvement and a rationale for its long-term use for this patient. In the absence of such documentation, the retrospective request for Alprazolam 1mg, #60 dos: 8/20/13 is not medically necessary and appropriate.