

<b>Case Number:</b>	CM13-0039302		
<b>Date Assigned:</b>	01/15/2014	<b>Date of Injury:</b>	03/27/2008
<b>Decision Date:</b>	05/07/2014	<b>UR Denial Date:</b>	09/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/04/2013

### 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 & Rehabilitation; has a subspecialty in Pediatric Rehabilitation 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 patient is a 54-year-old female who reported an injury on March 27, 2008. The patient is diagnosed with cervical myoligamentous sprain, cervical disc protrusions, bilateral upper extremity radiculopathy, and reactionary depression with anxiety, status post anterior cervical discectomy fusion (ACDF) in November 2011, and medication-induced gastritis with associated nausea. The patient was seen by [REDACTED] on August 23, 2013. The patient reported ongoing pain in her neck, radiating to bilateral upper extremities. The patient is currently received postoperative physical therapy. The patient has been treated with trigger point injections in the past. Physical examination on that date revealed tenderness to palpation along the posterior cervical musculature with significant rigidity, trigger points throughout the posterior cervical musculature, decreased range of motion, and decreased sensation. Treatment recommendations at that time included continuation of current medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RETROSPECTIVE MEDICATION REQUEST FOR NORCO:** 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): 74-82.

**Decision rationale:** This is a nonspecific request that does not include a dosage, frequency, or quantity. The request, as submitted, is not medically appropriate. Therefore, the request is non-certified.

**RETROSPECTIVE MEDICATION REQUEST FOR ULTRAM:** Upheld

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

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

**Decision rationale:** This is a nonspecific request that does not include a dosage, frequency, or quantity. The request, as submitted, is not medically appropriate. Therefore, the request is non-certified.

**RETROSPECTIVE MEDICATION REQUEST FOR FEXMID:** Upheld

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

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

**Decision rationale:** This is a nonspecific request that does not include a dosage, frequency, or quantity. The request, as submitted, is not medically appropriate. Therefore, the request is non-certified.

**RETROSPECTIVE MEDICATION REQUEST FOR ZOFTRAN:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation U.S. Food and Drug Administration

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) ONDANSETRON ANTIEMETICS

**Decision rationale:** This is a nonspecific request that does not include a dosage, frequency, or quantity. The request, as submitted, is not medically appropriate. Therefore, the request is non-certified.