

Case Number:	CM13-0049980		
Date Assigned:	12/27/2013	Date of Injury:	01/20/1995
Decision Date:	03/12/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	11/08/2013

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. 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 40-year-old female who reported an injury on 01/20/1995. Is currently diagnosed with lumbar discopathy and rule out internal derangement of bilateral hips. The patient was recently seen by [REDACTED] on 11/04/2013. The patient reported ongoing lower back pain with radiation to the lower extremities causing numbness and tingling. Physical examination reveals tenderness to palpation, positive straight leg raising, dysesthesia at the L5 and S1 dermatomes, and pain in the posterior lateral region of bilateral hips. Treatment recommendations included continuation of current medications, 2 intramuscular injections, and a urine drug screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen 550mg #120:

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: Chronic Pain Medical Treatment Guidelines state NSAIDS (non-steroidal anti-inflammatory drugs) are recommended for osteoarthritis at the lowest dose for the shortest

period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain in the lower back with radiation to bilateral lower extremities. The patient's physical examination continues to reveal tenderness to palpation, restricted range of motion, dysesthesia, and positive straight leg raising. Furthermore, Chronic Pain Medical Treatment Guidelines state there is no evidence of long term effectiveness for pain or function. Based on the clinical information received and the Chronic Pain Medical Treatment Guidelines, the request is non-certified.

Omeprazole 20mg #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): 68-69.

Decision rationale: Chronic Pain Medical Treatment 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. There is no evidence 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.

Ondansetron 8mg #60: Upheld

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

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, and Antiemetic.

Decision rationale: Official Disability Guidelines state Ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. Zofran is FDA approved for nausea and vomiting secondary to chemo therapy and radiation treatment, and has been approved for postoperative use. The patient does not meet criteria for the requested medication. As such, the request is non-certified.

Tramadol ER (extended release) 150mg #90: 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: Chronic Pain Medical Treatment Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Baseline pain and functional assessment should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. There is no significant change in the patient's physical examination that would indicate functional improvement. As the satisfactory response to treatment has not been indicated, the request is non-certified.

Sumatriptan Succinate 25mg #18: 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) Head Chapter, Triptans.

Decision rationale: Official Disability Guidelines state Triptans are recommended for migraine sufferers. Differences among them are in general relatively small, but clinically relevant for individual patients. There is no documentation of chronic migraines or headaches. The patient was initially prescribed this medication in 09/2013. There is no evidence of objective improvement. The medical necessity for the requested medication has not been established. Therefore, the request is non-certified.