

Case Number:	CM13-0062426		
Date Assigned:	12/30/2013	Date of Injury:	02/03/2010
Decision Date:	04/11/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/06/2013

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 and is licensed to practice in Illinois. 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 62-year-old male who sustained an unspecified injury on 02/03/2010. The patient was evaluated on 11/19/2013 for complaints of low back pain that radiated to the right lower extremity. The documentation indicated that the patient additionally complained of neck and right hip pain. The documentation submitted for review indicated that the patient's pain level was a 3.5/10 with medications and a 7.5/10 without medications. The patient's activities of daily living were reported to have limitations in the following areas: activity, ambulation, sleep and sex. On physical examination, objective findings were documented as the patient having a slow and antalgic gait, reduced range of motion secondary to pain to the lumbar spine, spinal vertebral tenderness at the L4-S1 levels and lumbar paraspinous muscle spasm upon palpation; and the patient was noted to appear in moderate distress. The patient's diagnoses were noted as lumbar radiculopathy, lumbar spinal stenosis, lumbar status post fusion, insomnia secondary to chronic pain, diabetes mellitus, coronary artery disease and status post hardware removal on 09/20/2013. The documentation submitted for review included Flector 1.3% patch and Percocet 10/325 mg as the medications for the treatment plan.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONDANSETRON ODT 8MG #30 WITH A REFILL: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation information from www.drugs.com

Decision rationale: The documentation submitted for review did not indicate that the patient was taking the medication requested. The medication was not included in the treatment plan nor were there indications as to the use of the medication. Drugs.com states that ondansetron is used to prevent nausea and vomiting that may be caused by surgery or medicine to treat cancer. The documentation submitted for review did not indicate that the patient had nausea or vomiting complaints. Therefore, the request for the medication is unclear. Given the information submitted for review, the request for ondansetron ODT 8 mg at 30 times two (60) is non-certified.

CYCLOBENZAPRINE 7.5MG #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

Decision rationale: The documentation submitted for review did not indicate the use of the medication as part of the treatment plan. The California MTUS Guidelines recommend the use of muscle relaxants as a second-line option for the short-term treatment of acute exacerbations in patients with chronic low back pain. The documentation submitted for review indicated the patient had muscle spasms to the lumbar spine region noted upon palpation. However, the documentation submitted for review indicated the patient's medication regimen was effective for treating her pain, and there was no indication of a change in treatment. Therefore, the need for additional medication is unclear. The documentation submitted for review did not indicate the medication was to be added to the treatment plan. Given the information submitted for review, the request for cyclobenzaprine 7.5 mg #120 is non-certified.

TRAMADOL ER 150MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing Management Page(s): 78.

Decision rationale: The documentation submitted for review did not indicate tramadol as part of the treatment plan. The California MTUS Guidelines recommend ongoing management of opioid therapy. Ongoing management should include pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant or nonadherent drug-related behaviors. The documentation submitted for review indicated that the patient was getting significant analgesic effect from her pain regimen. Therefore, the request for an additional opioid is unclear. Furthermore, the documentation submitted for review did not indicate that the patient

was having additional medications requested as part of the treatment plan. The California MTUS Guidelines recommend that opioid prescriptions be from a single practitioner. As the documentation submitted for review did not indicate the usage of the medication, it is unclear which physician prescribed the medication. Given the information submitted for review, the request for tramadol hydrochloride ER 150 mg #90 is non-certified.