MAXIMUS Federal Services

Case Number:	CM13-0066087		
Date Assigned:	01/03/2014	Date of Injury:	03/22/2000
Decision Date:	05/02/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/16/2013

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 Internal Medicine has a subspecialty in Pulmonary Diseases 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 injured worker is a 61-year-old female with a reported date of injury on 03/22/2000. The mechanism of injury was not provided within the medical records. The clinical note dated 12/04/2013 stated the injured worker complained of pain mostly referred from her neck, but also from her shoulder. The injured worker continued to have pain in her elbow, back, hip, and lower extremities with neuropathic pain/radicular pain. The injured worker had tenderness over the paracervical and paralumbar musculature. The injured worker was noted to be negative for muscle spasms in the paracervical musculature. The injured worker had pain with extension and lateral bending to the right and to the left. Positive muscle spasming in the paralumbar musculature was noted. The injured worker was unable to walk on tiptoes secondary to pain, unable to walk on heels secondary to pain. The patient had mild tenderness over the greater tuberosity of the right shoulder and tenderness over the right medial epicondyle at the elbow. The injured worker had diagnoses of medial epicondylitis, right elbow; bursitis/tendonitis, right shoulder; status post right shoulder arthroscopy; subacromial decompression; AC joint resection, cervical strain with multilevel disc protrusions; degenerative disc disease, cervical spine; lumbar strain with multilevel diagnostic procedures; degenerative disc disease, lumbar spine, right ankle strain, right hip greater trochanteric bursitis, and radiculitis bilateral lower extremities/ neuropathic pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 7.5 mg by mouth every day #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-71.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: The California MTUS recommends Cyclobenzaprine as an option, to use as a short course of therapy. The guidelines note Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and it comes at the price of greater adverse effects. The effects are greatest in the first 4 days of treatment, suggesting shorter courses may be better. Treatment should be brief. Within the provided documentation it was unclear when the injured worker began utilizing the medication. There was a lack of documented evidence of significant objective functional improvement with the use of the medication. Additionally, the requesting physician's rationale for the request was unclear. Therefore, the request is non-certified.

Diclofenac XR 100 mg by mouth every day #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-71.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67.

Decision rationale: California MTUS guidelines state there is no evidence of long-term effectiveness for pain or function, the specific recommendations: for osteoarthritis, including hip and knee: recommended at the lowest dose for the shortest period in patients with moderate to severe pain. For back pain, it is recommended as a second line of treatment after acetaminophen. For chronic low back pain, it is recommended as an option for short-term symptomatic relief. The documentation does not indicate when the medication was started. There was no evidence of objective functional improvement with the use of the medication. The requesting physician's rationale for the request was unclear. Therefore, the request is non-certified.

Ondansetron 4 mg by mouth every day #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013, Pain, Ondansetron(Zofran).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Antiemetics (for opioid nausea).

Decision rationale: The Official Disability Guidelines state that Ondansetron is recommended for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-

approved for postoperative use. Acute use is FDA-approved for gastroenteritis. Within the provided documentation the requesting physician's rationale for the request was unclear within the provided documentation. Within the provided documentation it was unclear if the injured worker had any complaints of nausea or vomiting. It did not appear the injured worker was undergoing chemotherapy and/or radiation, or the medication was being used post operatively. Therefore, the request is non-certified.

Tramadol ER 150 mg by mouth every day #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-95.

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

Decision rationale: California MTUS guidelines state ongoing review and documentation of pain relief, functional status, and appropriate medication use, and side effects should be performed. The guidelines note a pain assessment should be performed including current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the injured worker's decreased pain, increased level of function, or improved quality of life should be documented. The documentation should provide the 4 A's for ongoing monitoring: 4 domains have been proposed as most relevant for ongoing monitoring of chronic pain for patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. An adequate and complete assessment of the injured worker's pain was not documented including current pain, the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. There was not adequate documentation indicating the injured worker had significant objective functional improvement with the medication. Additionally, it was unclear if side effects or aberrant behaviors were present. Therefore, the request is non-certified.