MAXIMUS Federal Services

Case Number:	CM14-0104939		
Date Assigned:	08/01/2014	Date of Injury:	03/02/2009
Decision Date:	09/26/2014	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	07/07/2014

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 and is licensed to practice in Nevada. 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 records presented for review indicate that this 49-year-old gentleman was reportedly injured on March 2, 2009. The mechanism of injury is not listed in these records reviewed. The most recent progress note, dated March 11, 2014, indicates that there are ongoing complaints of neck pain radiating down the bilateral upper extremities, thoracic back pain, and low back pain radiating down the bilateral lower extremities. Pain is stated to be 10/10 without medications and 8/10 with medications. The physical examination demonstrated tenderness along the thoracic spine paraspinal muscles and along the vertebrae from T5 through T9. Examination of the lumbar spine noted tenderness along the vertebrae from L4 through S1. There was decreased lumbar spine range of motion secondary to pain. There was also tenderness noted at the coccyx. Diagnostic imaging studies of the thoracic spine showed a disc protrusion at TA - T9 and T9 - T10. An MRI the cervical spine showed a disc protrusion at C4 - C5 and C5 - C6. Nerve conduction studies of the upper and lower extremities were normal. Previous treatment includes. A request had been made for Ambien, ondansetron, tramadol ER, gabapentin, pantoprazole, vitamin D, metformin, Senokot, Norco, and tizanidine and was not certified in the pre-authorization process on June 25, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10mg #30: 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) - TWC/ODG Integrated Treatment/Disability Duration Guidelines; Pain (Chronic) - Ambien (updated 09/10/14).

Decision rationale: According to the Official Disability Guidelines, Zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. The guidelines specifically do not recommend them for long-term use for chronic pain. As such, this request for Ambien is not medically necessary.

Ondansetron HCL 4mg #30: 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 Other Medical Treatment Guideline or Medical Evidence: http://www.nlm.nih.gov/medlineplus/druginfo/meds/a601209.html.

Decision rationale: Ondansetron is a medication used to prevent nausea and vomiting caused by cancer chemotherapy, radiation therapy, and surgery. According to the attached medical record the injured employee does not have nausea and vomiting secondary to these conditions. Therefore this request for ondansetron is not medically necessary.

Tramadol HCL ER 100mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 82, 113 OF 127.

Decision rationale: The California MTUS guidelines support the use of Tramadol (Ultram) for short-term use after there is been evidence of failure of a first-line option, evidence of moderate to severe pain, and documentation of improvement in function with the medication. A review of the available medical records documents minimal pain relief from from 10/10 to 8/10 and no documentation of increased ability to function with the usage of tramadol. As such, the request for tramadol is not considered medically necessary.

Gabapentin 300mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs Page(s): 18.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 16-20, 49 OF 127.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines considers gabapentin to be a first-line treatment for neuropathic pain. Based on the clinical documentation provided, there is no evidence that the injured employee has any neuropathic pain nor are any radicular symptoms noted on physical examination were any nerve root involvement on MRI. Additionally, there is a normal nerve conduction study of both the upper and lower extremities. As such, this request for Neurontin is not medically necessary.

Pantoprazole Sodium DR #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 68 OF 127.

Decision rationale: Protonix (Pantoprazole) is a proton pump inhibitor useful for the treatment of gastroesophageal reflux disease (GERD) and is considered a gastric protectant for individuals utilizing non-steroidal anti-inflammatory medications. The California MTUS 2009 Chronic Pain Treatment Guidelines recommend proton pump inhibitors for patients taking NSAID's with documented GI distress symptom. Review of the attached medical record indicates that the injured employs not taking any anti-inflammatory medications at this time were there any complaints of gastroesophageal reflux. Considering this, this request for pantoprazole is not medically necessary.

Vitamin D 2,000 #60: 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), Pain, Vitamin D, Updated September 10, 2014.

Decision rationale: According to the Official Disability Guidelines the use of vitamin D is only recommended for chronic pain patients that supplementation of this vitamin is necessary. The progress note dated March 11, 2014 does not indicate that the injured employee has a vitamin D deficiency. Therefore this request for vitamin D is not medically necessary.

Meformin HCL 500mg #60: 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 Other Medical Treatment Guideline or Medical Evidence:http://www.nlm.nih.gov/medlineplus/druginfo/meds/a695033.html.

Decision rationale: According to the attached medical record it is unclear why this medication is prescribed for the injured employee at this time. It may have been prescribed by the injured employee's personal physician however this is unknown. Without further clarification, this request for metformin is not medically necessary.

Senokot-S 8/6-50mg #60: 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 Other Medical Treatment Guideline or Medical Evidence: http://www.nlm.nih.gov/medlineplus/druginfo/meds/a601112.html.

Decision rationale: Senokot is a medication used to assist with constipation sometimes caused by narcotic medications. The progress note dated March 11, 2014, does not indicate that the injured employee has any constipation. Additionally, both Norco and tramadol have been determined not to be medically necessary at this time. Considering this, this request for Senekot-S is not medically necessary.

Norco 10/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 74-78, 88, 91 OF 127.

Decision rationale: Norco (hydrocodone/acetaminophen) is a short acting opiate indicated for the management of moderate to severe breakthrough pain. The California MTUS guidelines support short-acting opiates at the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured employee has chronic pain; however, there is no objective clinical documentation of improvement in their pain or function with the current regimen. As such, this request for Norco is not medically necessary.

Tizanidine HCL 2mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants (for pain) Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26, MTUS (Effective July 18, 2009) Muscle relaxants (for pain) Page(s): 63-66 OF 127.

Decision rationale: Tizanidine is a muscle relaxant. According to the California Chronic Pain Medical Treatment Guidelines, muscle relaxants are indicated as a second line option for the short-term treatment of acute exacerbations of chronic low back pain. According to the most recent progress note, the injured employee does not have any complaints of acute exacerbations nor are there any spasms present on physical examination. For these reasons this request for tizanidine is not medically necessary.