

Case Number:	CM14-0104994		
Date Assigned:	09/24/2014	Date of Injury:	04/25/2012
Decision Date:	10/24/2014	UR Denial Date:	06/12/2014
Priority:	Standard	Application Received:	07/08/2014

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 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 injured worker is a 56-year-old male who reported an injury on 12/11/2012. The mechanism of injury was not submitted for clinical review. The diagnoses included cervicalgia and lumbago. Previous treatments included medication and physical therapy. The diagnostic testing included MRI. Within the clinical note dated 06/02/2014 it was reported the injured worker complained of constant pain in the low back. He reported the pain radiated into the lower extremities. He rated his pain 5/10 in severity. The injured worker reported cervical spine pain that is aggravated by repeated motions. He rated his cervical spine pain 8/10 in severity. Upon the physical examination the provider noted tenderness to palpation of the paravertebral muscles with spasm. The range of motion of flexion and extension was guarded and restricted. Sensation was normal. There was tenderness to palpation of the paravertebral muscles. There was a positive Spurling's maneuver noted in the documentation. The provider requested Naproxen, Omeprazole, Ondansetron, Orphenadrine, Tramadol, and Terocin. However, a rationale was not submitted for clinical review. The request for authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen 550mg #120: 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 Naproxen, page(s) 66-67. Page(s): 66-67..

Decision rationale: The request for Naproxen 550mg #120 is not medically necessary. The California MTUS Guidelines note Naproxen is a nonsteroidal anti-inflammatory drug for the relief of the signs and symptoms of osteoarthritis. The guidelines recommend Naproxen at the lowest dose for the shortest period of time in patients with moderate to severe pain. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted did not provide the frequency of the medication. Therefore, the request is not medically necessary.

Omeprazole 20mg #120: 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 GI symptoms & cardiovascular risk, page(s) 68-69. Page(s): 68-69..

Decision rationale: The request for Omeprazole 20mg #120 is not medically necessary. The California MTUS Guidelines note proton pump inhibitors such as Omeprazole are recommended for injured workers at risk for gastrointestinal events and/or cardiovascular disease. The risk factors for gastrointestinal events include over the age of 65, history of peptic ulcer, gastrointestinal bleeding or perforation, use of corticosteroids and/or anticoagulants. In the absence of risk factors for gastrointestinal bleeding events, proton pump inhibitors are not indicated when taking NSAIDs. The treatment of dyspepsia from NSAID usage includes stopping the NSAID, switching to a different NSAID, or adding an H2 receptor antagonist or proton pump inhibitor. There is lack of documentation indicating the medication had been providing objective functional benefit and improvement. The request submitted did not provide the frequency of the medication. Additionally, there is a lack of documentation indicating the injured worker had a diagnosis of dyspepsia secondary to NSAID therapy. Therefore, the request is not medically necessary.

Ondansetron 8mg #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), Pain, Zofran.

Decision rationale: The request for Ondansetron 8mg #30 is not medically necessary. The Official Disability Guidelines do not recommend Ondansetron for nausea and vomiting secondary to chronic opioid use. The clinical documentation submitted did not show evidence the injured worker was treated for nausea and vomiting secondary to chronic opioid use. The

request submitted failed to provide the frequency of the medication. Additionally, there is lack of clinical documentation indicating the medication had been providing objective functional benefit and improvement. Therefore, the request is not medically necessary.

Orphenadrine 100mg #120: 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 Muscle Relaxants, page(s) 63, 64. Page(s): 63, 64..

Decision rationale: The request for Orphenadrine 100mg #120 is not medically necessary. The California MTUS Guidelines recommend nonsedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. The guidelines note the medication is not recommended to be used for longer than 2 to 3 weeks. There is a lack of documentation indicating the medication had been providing objective functional benefit and improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

Tramadol 150mg #90: 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 Opioids, criteria for use, On-Going Management, page(s) 78. Page(s): 78..

Decision rationale: The request for Tramadol 150mg #90 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed provide the frequency of the medication. Additionally, the use of a urine drug screen was not submitted for clinical review. Therefore, the request is not medically necessary.

Terocin Patch 30: 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 Topical NSAIDs, page(s) 111-112. Page(s): 111-112..

Decision rationale: The request for Terocin patch 30 is not medically necessary. The California MTUS Guidelines note topical NSAIDs are recommended for osteoarthritis and tendonitis, in particular that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. The request submitted did not specify a treatment site. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. Additionally, the request submitted did not specify a frequency. Therefore, the request is not medically necessary.