

Case Number:	CM14-0018032		
Date Assigned:	04/16/2014	Date of Injury:	05/07/2007
Decision Date:	06/02/2014	UR Denial Date:	01/27/2014
Priority:	Standard	Application Received:	02/12/2014

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 & Rehabilitation and is licensed to practice in Texas. 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 52 year old male with a reported injury date of 05/02/2007; the mechanism of injury was not provided. Diagnoses include status post posterior C4-C& hybrid cervical reconstruction, status post left L5-S1 L & D, rule out internal derangement right shoulder, bilateral cubital tunnel syndrome, right greater than left. The clinical note dated 10/23/2013 noted that the injured worker is status post cervical reconstruction performed on 09/20/2103 and reported that the majority of the radicular pain in the upper extremities has resolved. Documented objective findings included no symptomatology of radiculopathy noted in the upper extremities. There was also noted tenderness at the right subacromial space, positive Hawkins and impingement signs, and unrated pain with right shoulder terminal motion. Additional objective findings included positive Tinel's in bilateral elbows with extension of symptomatology in the ulnar two digits, positive elbow flexion test, and noted discomfort around the arcade of Struthers. Further objective findings included tenderness at the lumbar paravertebral muscles with spasm, limited lumbar motion, positive seated nerve root test, and dysesthesias at the L5 and S1 dermatomes.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION FOR NAPROXEN SODIUM 550MG #100: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Inflammatory Medications; NSAIDs (Non-Steroidal Anti-Inflammatory Drugs) Page(s): 22; 67-68.

Decision rationale: The request for a prescription for Naproxen Sodium 550mg # 100 is not medically necessary. It was noted that the injured worker is status post cervical reconstruction performed on 09/20/2103. It was also noted that the majority of the radicular pain in the upper extremities had been resolved. Documented objective findings included noted tenderness at the right subacromial space, positive Hawkins and impingement signs, and unrated pain with right shoulder terminal motion. Additional objective findings included positive Tinel's in bilateral elbows with extension of symptomatology in the ulnar two digits, positive elbow flexion test, and noted discomfort around the arcade of Struthers. Further objective findings included tenderness at the lumbar paravertebral muscles with spasm, limited lumbar motion, positive seated nerve root test, and dysesthesias at the L5 and S1 dermatomes. The California MTUS guidelines state that anti-inflammatory are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume; however, long-term use may not be warranted. It is unclear what current medications the injured worker is currently prescribed as there was no documentation provided of medication history. The California MTUS guidelines also recommended the use of non-steroidal anti-inflammatory drugs as an option for short-term symptomatic relief of chronic low back pain. However, it remains unclear as to what symptomatology the medication is intended to treat. As such this request for a prescription for Naproxen Sodium 550mg # 100 is not medically necessary.

PRESCRIPTION FOR OMEPRAZOLE DELAYED-RELEASE 20MG #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms & Cardiovascular Risk Page(s): 68.

Decision rationale: The request for a prescription for omeprazole delayed-release 20mg #120 is not medically necessary. It was noted that the injured worker is status post cervical reconstruction performed on 09/20/2103. It was also noted that the majority of the radicular pain in the upper extremities had been resolved. Documented objective findings included noted tenderness at the right subacromial space, positive Hawkins and impingement signs, and unrated pain with right shoulder terminal motion. Additional objective findings included positive Tinel's in bilateral elbows with extension of symptomatology in the ulnar two digits, positive elbow flexion test, and noted discomfort around the arcade of Struthers. Further objective findings included tenderness at the lumbar paravertebral muscles with spasm, limited lumbar motion, positive seated nerve root test, and dysesthesias at the L5 and S1 dermatomes. The California MTUS guidelines recommend proton pump inhibitors for use in patients at intermediate risk for gastrointestinal events. However, the medical necessity of this medication cannot be determined due to the lack of objective physical findings or documentation of a history

of GI symptomatology. As such this request for a prescription for omeprazole delayed-release 20mg #120 is not medically necessary.

PRESCRIPTION FOR ONDANSETRON 8MG #30 X2: 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 Official Disability Guidelines (ODG), Pain Chapter, Ondansetron (Zofran).

Decision rationale: noted that the injured worker is status post cervical reconstruction performed on 09/20/2103. It was also noted that the majority of the radicular pain in the upper extremities had been resolved. Documented objective findings included noted tenderness at the right subacromial space, positive Hawkins and impingement signs, and unrated pain with right shoulder terminal motion. Additional objective findings included positive Tinel's in bilateral elbows with extension of symptomatology in the ulnar two digits, positive elbow flexion test, and noted discomfort around the arcade of Struthers. Further objective findings included tenderness at the lumbar paravertebral muscles with spasm, limited lumbar motion, positive seated nerve root test, and dysesthesias at the L5 and S1 dermatomes. The Official Disability Guidelines not recommend the use of Ondansetron (Zofran) for the nausea and vomiting secondary to chronic opioid use. The medical necessity of this medication cannot be determined due to the lack of documentation as to why this medication is being prescribed and a lack of objective and physical findings of nausea and vomiting. As such the request for a prescription for Ondansetron 8mg #30 x 2 is not medically necessary.