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| Case Number: | CM14-0110519 | | |
| Date Assigned: | 08/01/2014 | Date of Injury: | 11/14/2003 |
| Decision Date: | 09/15/2014 | UR Denial Date: | 06/24/2014 |
| Priority: | Standard | Application Received: | 07/16/2014 |

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 & Pain Management, has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma and 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 a 44-year-old female who reported an injury 11/14/2003. The mechanism of injury was not provided within the medical records. The clinical note dated 06/05/2014 indicated diagnosis of cervicalgia. The injured worker reported constant pain to the cervical spine aggravated by repetitive motion of the neck, including pushing, pulling, lifting, forward reaching, and working at or above shoulder level. The pain was characterized as sharp that radiated into the upper extremities associated with headaches described as migrainous in nature, as well as tension between the shoulder blades. The injured worker reported her pain as 8 /10. On physical examination of the cervical spine, there was tenderness to the paravertebral muscles with spasms. The injured worker had a positive axial loading compression test with a positive Spurling's maneuver. The injured worker's range of motion was limited with pain. The injured worker's sensation and strength was noted at 4/5. The worker's prior treatment included medication management. The injured worker's medication regimen was not provided for review. The provider submitted request for diclofenac sodium, orphenadrine citrate, omeprazole, and ordansetron. A Request for Authorization dated 06/17 was submitted for the above medications; however, a rationale was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac Sodium ER (Voltaren) 100 mg.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS. Decision based on Non-MTUS Citation ODG Pain Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain, Voltaren Gel Page(s): 111.

Decision rationale: The California MTUS states Voltaren Gel 1% (diclofenac) is an FDA-approved agent indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). There is lack of documentation of efficacy and functional improvement with the use of this medication. In addition, it was not indicated if this was a trial request or if the injured worker had been utilizing this medication. Moreover, if the injured worker had been utilizing this medication, the injured worker rates her pain at 8/10. There is no indication that the use of Voltaren has resulted in diminished pain levels or functional improvement. Moreover, the provider did not provide a rationale for the request. Furthermore, the provider did not indicate a frequency or quantity for this medication. Therefore, the request is not medically necessary and appropriate.

Orphenadrine Citrate, count 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation ODG- Pain Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxant, Orphenadrine Page(s): 41-42.

Decision rationale: The CA MTUS guidelines recommend Orphenadrine Citrate as an option, using a short course of therapy. Orphenadrine Citrate is a skeletal muscle relaxant and a central nervous system (CNS) depressant. There is lack of documentation of efficacy and functional improvement with the use of this medication. In addition, it was not indicated if this was a trial prescription or if the injured worker had been utilizing this medication. Moreover, the provider did not indicate a rationale for this medication. Additionally, the request does not indicate a dosage or frequency for this medication. Therefore, the request is not medically necessary and appropriate.

Omeprazole 20 mg, count 120.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS. Decision based on Non-MTUS Citation Official Disability Guidelines-Pain Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The CA MTUS guidelines recommend the use of proton pump inhibitors if there is a history of gastrointestinal bleeding or perforations, a prescribed high dose of NSAIDs and a history of peptic ulcers. There is also a risk with long-term utilization of PPI (> 1 year) which has been shown to increase the risk of hip fracture. The documentation submitted did not indicate the injured worker had findings that would support she was at risk for gastrointestinal bleeding or perforations or peptic ulcers. In addition, it was not indicated whether the injured worker was taking NSAIDs. Moreover, there was lack of documentation of any medications that the injured worker was taking, to warrant the use of a proton pump inhibitor. Additionally, the request did not indicate a dosage or a frequency for the medication. In addition, there was lack of documentation and efficacy of functional improvement with the use of this medication. Therefore, the request is not medically necessary and appropriate.

Ordansetron 8 mg ODT, count 30.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS. Decision based on Non-MTUS Citation Official Disability Guidelines-Pain Procedure Summary.

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

Decision rationale: The Official Disability Guidelines State Ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. The documentation submitted did not indicate the injured worker had findings that would support he was at risk for nausea or vomiting. In addition, the Official Disability Guidelines indicate Zofran is not recommended for nausea and vomiting secondary to chronic opioid use. Moreover, the guidelines further state if nausea and vomiting remain prolonged other etiologies of these symptoms should be evaluated for. Furthermore, the request does not indicate a frequency. Additionally, there is lack of documentation of efficacy and functional improvement with the use of this medication. Additionally, the provider did not indicate a rationale for the request. Therefore, the request for Ordansetron is not medically necessary and appropriate.