

Case Number:	CM14-0122138		
Date Assigned:	08/06/2014	Date of Injury:	06/18/2013
Decision Date:	09/22/2014	UR Denial Date:	07/08/2014
Priority:	Standard	Application Received:	08/01/2014

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 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 64-year-old female who reported an injury on 06/19/2013. The mechanism of injury was not provided within the medical records. The clinical note dated 05/17/2014 is handwritten and hard to decipher. The injured worker was status post PLIF and reported feeling well. In the physical examination of the cervical spine, the injured worker had a well-healed scar. The clinical note dated 03/04/2014 indicated the injured worker was diagnosed with hypertension, left ventricular hypertrophy, and lumbar spine pain. A clinical note dated 04/07/2014 indicated the injured worker was status post L4-S1 posterior lumbar interbody fusion "L4-A1 L4-S1" bilateral rigid segmental internal fixation/L4-S1 bilateral posterolateral/intertransverse fusion/L4-S1 reduction listhesis with realignment of functional kyphotic deformity back to lordosis. The injured worker's prior treatments included diagnostic imaging, surgery, and medication management. The injured worker's medication regimen was not provided for review. The provider submitted a request for Diclofenac, Omeprazole, Ondansetron, Tramadol, and Orphenadrine. A Request for Authorization was not submitted for review to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac Sodium ER 100mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

Decision rationale: The request for Diclofenac Sodium ER 100 mg #120 is not medically necessary. The CA MTUS Guidelines recognize ibuprofen as a non-steroidal anti-inflammatory

drug. Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. The diclofenac sodium was modified on 07/07/2014. In addition, there is a lack of documentation of efficacy and functional improvement with the use of this medication. Moreover, it was not indicated how long the injured worker had been utilizing this medication. Additionally, the request does not indicate a frequency. Therefore, the request is not medically necessary.

Omeprazole 20mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms.

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

Decision rationale: The request for Omeprazole 20 mg #120 is not medically necessary. 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. There is a lack of clinical information provided indicating the injured worker had gastritis. In addition, the clinical notes reviewed did not indicate any medications the injured worker was taking. Therefore, it is unable to be determined if any medication would warrant the use of a proton pump inhibitor. Additionally, the provider did not indicate a rationale for the request. Moreover, the request does not indicate a frequency. Therefore, the request is not medically necessary.

Ondansetron 8mg ODT #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, Pain chapter.

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 request for Ondansetron 8 mg ODT #30 is not medically necessary. The Official Disability Guidelines do not recommend Ondansetron (Zofran) for nausea and vomiting secondary to chronic opioid use. The documentation submitted did not indicate the injured worker had findings that would support she was at risk for nausea or vomiting. In addition, the provider did not indicate a rationale for the request. Furthermore, the request does not indicate a frequency. Therefore, the request is not medically necessary.

Tramadol ER 150mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 113.

Decision rationale: The request for Tramadol ER 150 mg #90 is not medically necessary. The California MTUS guidelines state Tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. There is a lack of documentation of efficacy and functional improvement with the use of Tramadol. In addition, the request was modified for medical necessity on 07/07/2014. Additionally, the request does not indicate a frequency. Therefore, the request is not medically necessary.

Orphenadrine Citrate #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 relaxant Page(s): 65.

Decision rationale: The request for Orphenadrine Citrate #120 is not medically necessary. The California Chronic Pain Medical Treatment Guidelines recommend the use of muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. The documentation submitted did not indicate the injured worker had findings that would support she was at risk for acute exacerbations or muscle spasms. In addition, the provider did not indicate a rationale for the request. Furthermore, the request does not indicate a frequency. Therefore, the request is not medically necessary.