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| Case Number: | CM14-0124177 | | |
| Date Assigned: | 08/08/2014 | Date of Injury: | 03/30/2012 |
| Decision Date: | 09/22/2014 | UR Denial Date: | 07/08/2014 |
| Priority: | Standard | Application Received: | 08/05/2014 |

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 Pain Medicine and is licensed to practice in Texas and Ohio. 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 54-year-old female who reported an injury 03/30/2012. The mechanism of injury was not provided within the medical records. The clinical note dated 04/18/2014 is handwritten and hard to decipher. The injured worker's diagnoses included cervicalgia, lumbago, and joint pain (leg). The injured worker reported constant severe pain of the cervical spine/lumbar spine with radiation to the right knee and ankle pain. On physical examination, there was tenderness at the cervical spine and lumbar spine with spasms. The injured worker had right knee and ankle pain with decreased range of motion and a positive straight leg raise. The injured worker's treatment plan included medication prescriptions, pending physical therapy and TENS unit. The injured worker's prior treatments were not provided for review. The injured worker's medication regimen was not provided for review. The provider submitted a request for omeprazole, ondansetron, orphenadrine, and tramadol. 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:

Omeprazole 20mg Quantity 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI and Cardiovascular risk factors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, 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. Within the clinical notes reviewed, there was lack of documentation of any medication the injured worker was taking. Therefore, it is unable to be determined if any medication will warrant the use of a proton pump inhibitor. In addition, the documentation submitted did not indicate the injured worker had findings that will support she was at risk for gastrointestinal bleeding or perforations or a peptic ulcer. Moreover, the request did not indicate a frequency for omeprazole. Therefore, the request is not medically necessary and appropriate.

Ondansetron 8mg ODT Quantity 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 (for Opioid Nausea).

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

Decision rationale: 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 Official Disability Guidelines do not recommend Zofran secondary to chronic opioid use. Within the clinical notes reviewed, there was lack of documentation for any medications the injured worker was taking; therefore, it is unable to be determined if any medications would warrant the use of ondansetron. Furthermore, the provider did not indicate a rationale for the request. Additionally, the request did not indicate a frequency for ondansetron. Therefore, the request is not medically necessary and appropriate.

Orphenadrine Citrate Quantity 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxant Page(s): 65.

Decision rationale: 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. Although the injured worker reported low back pain with spasms, there is lack of a quantified pain assessment by the injured worker. In addition, it was not indicated if a first line option had been tried. Moreover, the request did not

indicate a frequency for this medication. Therefore, the request is not medically necessary and appropriate.

Tramadol ER 150mg Quantity 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 California MTUS guidelines state tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. It was not indicated that a first line analgesic had been tried. In addition, there is lack of a quantified pain assessment completed by the injured worker. Moreover, the request does not indicate a frequency. Therefore, the request is not medically necessary and appropriate.