

Case Number:	CM14-0124183		
Date Assigned:	08/08/2014	Date of Injury:	01/31/2013
Decision Date:	09/15/2014	UR Denial Date:	07/21/2014
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 Anesthesiology, has a subspecialty in Pain Medicine 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 a 37 year old female who sustained an injury on 01/31/13. No specific mechanism of injury was noted. The injured worker was followed for complaints of continuing low back pain that failed prior physical therapy medications and injections. The injured worker was recommended for lumbar fusion at L4-5 to address persistent foot drop and low back pain radiating to the lower extremities. As of 07/01/14 the injured worker continued to have complaints of neck pain aggravated by range of motion. The injured worker described associated headaches and low back pain radiating to the lower extremities. On physical examination there was tenderness to palpation in the neck and low back with paravertebral spasms. Numbness and tingling was noted in the lateral thigh and posterior leg and foot in L5-S1 distribution. Weakness was mild at the extensor hallucis longus and ankle plantarflexors. Recommendation was for continuing physical therapy for the lumbar spine and cervical spine. The requested medications including Diclofenac 100mg #120, Omeprazole 20mg #120, Ondansetron 8mg #30, Orphenadrine ER 100mg #120 and Tramadol ER 150mg #90 were denied by utilization review on 07/02/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac Sodium ER (Voltaren SR) 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 NSAIDs Page(s): 67-68.

Decision rationale: The chronic use of prescription non-steroidal anti-inflammatory drugs (NSAIDs) is not recommended by current evidence based guidelines as there is limited evidence regarding their efficacy as compared to standard over-the-counter medications for pain such as Tylenol. Per guidelines, NSAIDs can be considered for the treatment of acute musculoskeletal pain secondary to injury or flare ups of chronic pain. There is no indication that the use of NSAIDs in this case is for recent exacerbations of the injured workers' known chronic pain. As such, the injured worker could have reasonably transitioned to an over-the-counter medication for pain.

Omeprazole (Delayed-Release Capsules) 20mg #120: Upheld

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

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, proton pump inhibitors.

Decision rationale: The clinical records provided for review did not discuss any side effects from oral medication usage including gastritis or acid reflux. There was no other documentation provided to support a diagnosis of gastroesophageal reflux disease. Given the lack of any clinical indication for the use of a proton pump inhibitor this reviewer would not have recommended this request as medically necessary.

Ondansetron (ODT tablets) 8mg #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 Procedure Summary, Antiemetics.

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, Anti-Emetics.

Decision rationale: In regards to the request for Ondansetron 8mg #30 this reviewer would not have recommended this request as medically appropriate. Ondansetron is Food and Drug Administration indicated to address nausea and vomiting secondary to chemotherapy or other radiative therapy. Other indications included post-operative nausea and vomiting. None of these indications were present in the clinical documentation submitted for review. Guidelines did not support off label use of Ondansetron to address nausea and vomiting side effects from oral medications. Guidelines instead recommended alteration of dose or trials of different

medications to avoid nausea and vomiting. Therefore this reviewer would not recommend this request as medically necessary.

Orphenadrine Citrate ER 100mg #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 Relaxants Page(s): 63-67.

Decision rationale: The chronic use of muscle relaxers is not recommended by current evidence based guidelines. At most, muscle relaxers are recommended for short term use only. The efficacy of chronic muscle relaxer use is not established in the clinical literature. There is no indication from the clinical reports that there had been any recent exacerbation of chronic pain or any evidence of a recent acute injury. Therefore, this reviewer would not have recommended ongoing use of this medication.

Tramadol Hydrochloride ER 150mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use for a therapeutic trial of opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 88-89.

Decision rationale: The injured worker has been utilizing this medication over an extended period of time. Per current evidence based guidelines, the use of an ER analgesic such as Tramadol can be considered an option in the treatment of moderate to severe musculoskeletal pain. The benefits obtained from narcotic-like analgesics diminishes over time and guideline recommend that there be ongoing indications of functional benefit and pain reduction to support continuing use of this medication. Overall, there is insufficient evidence in the clinical literature that long term use of narcotic medications results in any functional improvement. No specific pain improvement was attributed to the use of this medication. The clinical documentation also did not include any compliance measures such as toxicology testing or long term opiate risk assessments (COMM/SOAPP) to determine risk stratification for this claimant. This would be indicated for Tramadol given the long term use of this medication. As there is insufficient evidence to support the ongoing use of Tramadol, this reviewer would not have recommended this request as medically necessary.