

Case Number:	CM14-0124381		
Date Assigned:	08/08/2014	Date of Injury:	08/20/2009
Decision Date:	12/22/2014	UR Denial Date:	07/22/2014
Priority:	Standard	Application Received:	08/06/2014

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, has a subspecialty in Interventional Spine 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 patient is a 59-year-old female with a date of injury of 08/22/2009. According to progress report 06/19/2014, the patient presents with continued cervical spine pain with radiation of pain into the upper extremity with associated headaches. Pain is rated as 5/10 on a pain scale. The patient also reports low back pain with radiation of pain into the lower extremities. Low back pain is rated as 8/10. Examination of the cervical spine revealed palpable vertebral muscle tenderness with spasm. A positive axial loading compression test is noted. Range of motion was limited due to pain. Examination of the lumbar spine revealed palpable paravertebral muscle tenderness with spasm and positive seated nerve root test. Range of motion was restricted and guarded in the standing flexion and extension. The listed diagnoses are: 1. Cervicalgia. 2. Plantar fasciitis. 3. Lumbago. 4. Carpal tunnel syndrome. 5. Shoulder region dis NEC. The physician is requesting refill of medications. Utilization review denied the request on 07/22/2014. The treatment reports from 04/17/2014 through 08/21/2014 were provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren SR 100mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines the use of NSAID Page(s): 22.

Decision rationale: This patient presents with chronic neck and low back pain. The current request is for Voltaren SR 100 mg #120. The MTUS Guidelines page 22 supports the use of NSAID as a first-line of treatment for chronic LBP. Review of the medical file indicates the patient has been prescribed Voltaren since at least 05/15/2014. In this case, the physician does not provide a discussion regarding this medication's efficacy. MTUS page 60 requires recording of pain assessment, functional changes when medications are used for chronic pain. Given the lack of discussion regarding whether this medication has been effective, continuation of use cannot be supported. The request is not medically necessary.

Omeprazole 20mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Omeprazole Page(s): 68-69.

Decision rationale: This patient presents with chronic neck and low back pain. The current request is for omeprazole 20 mg #120. The MTUS Guidelines pages 68 and 69 states that Omeprazole is recommended with precaution for patients at risk for gastrointestinal events: (1) Age is greater than 65, (2) History of peptic ulcer disease and GI bleeding or perforation, (3) Concurrent use of ASA or corticosteroid and/or anticoagulant, (4) High dose/multiple NSAID. Review of the medical file indicates the patient has been utilizing Omeprazole concurrently with the NSAID Voltaren since 05/05/2014. The patient has been taking NSAID on a long term basis, but the physician does not document dyspepsia or GI issues. Routine prophylactic use of PPI without documentation of gastric issues is not supported by the guidelines without GI-risk assessment. The request is not medically necessary.

Ondansetron ODT 8mg #30 x 2 refills: 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 (Chronic) chapter, Antiemetics (for opioid nausea)

Decision rationale: This patient presents with chronic neck and low back pain. The current request is for Ondansetron ODT 8 mg #30 x2 refills. The requesting physician states that this medication is prescribed for patient's nausea associated with the headaches that are presented with his cervical spine pain. This medication is the generic name for Zofran. The MTUS and ACOEM Guidelines do not discuss Ondansetron; however, the ODG Guidelines has the following regarding antiemetic ""Not recommended for nausea and vomiting secondary to

chronic opioid use. It is recommended for acute use as noted below per FDA-approved indications." "Ondansetron (Zofran): This drug is a serotonin 5-HT₃ receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use. Acute use is FDA-approved for gastroenteritis." The physician is requesting this medication for the patient's nausea associated with headaches. The ODG Guidelines do not support the use of Ondansetron other than nausea following chemo, acute gastroenteritis or for post-operative use. The request is not medically necessary.

Cyclobenzaprine Hydrochloride 7.5mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: This patient presents with chronic neck and low back pain. The current request is for Cyclobenzaprine hydrochloride 7.5 mg #120. The MTUS Guidelines page 63 regarding muscle relaxants states, "recommended non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations of patients with chronic LBP." Review of the medical file indicates the patient has been utilizing this medication since 05/15/2014 and the physician is recommending refill of #120. In this case, muscle relaxants are not recommended for long-term use. Therefore, the request is not medically necessary.

Tramadol Hydrochloride ER 150mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 88-89,78.

Decision rationale: This patient presents with chronic neck and low back pain. The physician is requesting Tramadol hydrochloride ER 150 mg #90. The MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." The MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. A review of the medical file indicates the patient has been utilizing this medication since at least 09/23/2011. In this case, recommendation for further use of Tramadol cannot be supported as the physician does not provide before and after pain scale to show analgesia and no specific ADLs are discussed. No change in work status or return to work is documented to show significant functional improvement. Adverse side effects and aberrant behaviors are not addressed. In addition, there are no Urine drugs screens and CURES report is not provided.

Given the lack of sufficient documentation for opiate management, the request is considered not medically necessary.

Menthoderm Gel 120gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medication for chronic pain; Salicylate topicals Page(s): 60,105.

Decision rationale: This patient presents with chronic neck and low back pain. The current request is for Mentoderm gel 120 gm. Mentoderm gel contains menthol and methyl salicylate, and NSAID. The MTUS Guidelines allow for the use of topical NSAID for peripheral joint arthritis and tendinitis. MTUS guidelines support Ben-Gay, which contains similar products as Mentoderm, for acute and chronic pain conditions, particularly osteoarthritis. This patient has a diagnosis of carpal tunnel syndrome which meets the indication for use of Mentoderm gel. However, the patient has been provided this topical agent since 5/5/14 with no documentation of its efficacy. The MTUS page 60 require documentation of pain assessment and functional gains when medications are used for chronic pain. Given the lack of discussion regarding efficacy, the request is considered not medically necessary.