

Case Number:	CM14-0126918		
Date Assigned:	09/16/2014	Date of Injury:	08/09/1999
Decision Date:	11/17/2014	UR Denial Date:	07/16/2014
Priority:	Standard	Application Received:	08/11/2014

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 Emergency Medicine 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:

Patient with reported date of injury on 8/9/1999. Mechanism of injury is not well described; it merely mentions a motor vehicle collision. Patient has a diagnosis of lumbar disk displacement, cervical disk degeneration, lumbar radiculopathy, cervical radiculitis, post-laminectomy syndrome, cervical disc displacement and low back pain. Patient also has multiple medical problems including gastropathy, diabetes, fibromyalgia, irritable bowel syndrome, hypertension, diabetes, acid reflux and left ventricular hypertrophy. Patient is reportedly post lumbar spine surgery, spinal cord stimulator, carpal tunnel surgery and knee surgery. Medical reports reviewed. The original request for services was dated 7/11/14 and received for UR on 7/14/14. Records were received dated after UR date and request dates. The majority (over 300 pages) were related to inpatient stay after surgery. These records were not reviewed unless they directly pertain to the original request and/or reason for that request since prospective information does not retrospectively change the original criteria used for independent medical review as per MTUS guidelines. Reports were reviewed until 7/19/14 which is the date post surgery. There is no documentation by the providers anywhere about why the medications under review were requested. Patient complains of low back pain. Pain radiates to R buttock and down thigh to foot. Pain worsens with any activity. Pain is 6-7/10. Patient reportedly underwent cervical spine surgery on 7/18/14. Note from 7/9/14 does not report nausea or abdominal complaints. Pre-surgical Objective exam revealed tenderness to C6-7 region bilaterally, occipital region of neck, 2nd intercostal space in midclavicular region. Decreased range of motion of lumbar spine. Antalgic gait. L knee with restricted range of motion, swelling in both legs. Decreased muscle mass to R quadriceps. Positive Tinel's sign on L hand with negative Homan's. Dysaesthesia at C5-6 dermatomes. No imaging reports or electrodiagnostic reports were provided for review. No medication list was provided for review. Pt is noted to be on Levemir, Novolog, Aciphex,

Neurontin, Percocet, cymbals, Crestor, Benicar and Victoza. Urine Drug Screen(5/14/14) was positive for oxycodone, oxymorphone, acetaminophen and noroxycodone. Independent Medical Review is for Diclofenac Sodium ER(Voltaren ER) 100mg #120, Omeprazole 20mg #120, Ondansetron 8mg 330, Orphenadrine(Norfex) ER 100mg #120 and Tramadol ER 150mg #90. Prior UR on 7/16/14 recommended non-certification. It recommended weaning off Orphenadrine and Tramadol. It approved sumatriptan.

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 Refills: 0: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risks> Page(s): 68-69.

Decision rationale: Diclofenac is a Non-steroidal anti-inflammatory drug (NSAID). As per MTUS Chronic Pain guidelines, NSAIDs is recommended for short term treatment or for exacerbations of chronic pains. It is mostly recommended for osteoarthritis. It may be used for chronic back pains but recommendations are for low dose and short course only. There are significant side effects if used chronically. There is no documentation anywhere if diclofenac is used chronically or acutely or reasoning behind its use. Patient has extensive cardiovascular risk factors. NSAIDs are not recommended for use in patients with significant cardiovascular risk factors unless there is proper reasoning and monitoring. The documentation fails to provide any documentation to support the prescription for Diclofenac.

Omeprazole 20mg #120 Refills - 0: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risks>, Page(s): 68-69.

Decision rationale: There is no documentation provided as to why Prilosec was requested. Omeprazole/Prilosec is a proton-pump inhibitor used for dyspepsia from NSAID use or gastritis/peptic ulcer disease. As per MTUS guidelines, PPIs may be used in patients with high risk for gastric bleeds or problems or signs of dyspepsia. The documentation concerning the patient does not meet any high risk criteria to warrant PPIs and there is no documentation provided to support NSAID related dyspepsia. Patient has a diagnosis of gastroesophageal reflux disease but there is no record if GERD is related to the injury or medication use. NSAID is not indicated in this patient (see review of Diclofenac) and therefore a PPI is not indicated as well. Omeprazole is not medically necessary.

Ondansetron 8 mg ODT #30 Refills - 0: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation

<http://www.nlm.nih.gov/medlineplus/druginfo/meds/a601209.html>

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)>, <Antiemetics(for opioid nausea)>

Decision rationale: There are no relevant sections in the MTUS Chronic pain or ACOEM guidelines concerning this topic. Ondansetron is an anti-nausea medication. As per Official Disability Guide (ODG), anti emetics should only be used for short term nausea associated with opioids. Long term use is not recommended. Documentation provided by treating physicians does not document why this was prescribed. There is no documentation of nausea. The number of tablets prescribed does not meet criteria for short term use. Ondansetron is not medically necessary.

Orphenadrine citrate ER (Norflex) 100mg #120 Refills - 0: 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(for pain)> Page(s): 63-65.

Decision rationale: Norflex is an anti-spasmodic type muscle relaxant. As per MTUS Chronic pain guidelines, muscle relaxants have some benefit for pain but data to support its use is very limited. It should be used with caution. As per MTUS guidelines, Norflex has an unknown mechanism of action and limited data to show efficacy. There is some risk of euphoria and side effects. Pt appears to be on this chronically. However, there is no documentation of improvement in muscle spasms or close monitoring for side effects by medical provider, Norflex is not recommended. Norflex is not medically necessary.

Tramadol ER 150mg #90 Refills - 0: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids> Page(s): 76-78.

Decision rationale: Tramadol/Ultram is a Mu-agonist, an opioid-like medication. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. There is no documentation as to why this medication was requested. Pt. appears to be on other opioids such as Percocet.

Documentation fails to meet the appropriate documentation required by MTUS. There is no documentation of pain improvement, no appropriate documentation of objective improvement and there is no mention about a pain contract or screening for abuse. Documentation fails MTUS guidelines for chronic opioid use. Tramadol is not medically necessary.