

Case Number:	CM14-0133139		
Date Assigned:	08/22/2014	Date of Injury:	10/05/2005
Decision Date:	12/18/2014	UR Denial Date:	07/28/2014
Priority:	Standard	Application Received:	08/20/2014

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 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 50-year-old male who reported an injury on 10/05/2005. The mechanism of injury was due to a motor vehicle accident. The injured worker has a diagnosis of lumbago, unspecified disorder of the cervical region, and lower leg pain in the joints. Medical treatment consists of surgery, physical therapy, medication therapy, and ESIs. Medications included Omeprazole, Ondansetron, Cyclobenzaprine, Tramadol, and Levofloxacin. No diagnostics were submitted for review. On 07/11/2014, it was noted that the injured worker's review of systems was unchanged. Physical examination noted that the injured worker was well nourished, well developed, and in no acute distress. Mood and affect were appropriate. The injured worker's was alert and oriented to person, place, and time x3. The injured worker's gait was intact. Progress note stated that the treatment plan was discussed with the injured worker. Rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro (DOS 7/14/14): Omeprazole 20mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Chapter

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

Decision rationale: The request for retro (DOS 7/14/14): Omeprazole 20mg #120 is not medically necessary. The California MTUS Guidelines state that proton pump inhibitors may be recommended to treat dyspepsia secondary to NSAID therapy. The addition of a proton pump inhibitor is also supported for patients taking NSAID medications who have cardiovascular disease or significant risk factors for gastrointestinal events. The submitted documentation lacked any evidence as to how long the injured worker had been taking any NSAID. Furthermore, there was no documentation indicating the injured worker having complaints of dyspepsia with the use of the medication, cardiovascular disease, or significant risk factors for gastrointestinal events. In the absence of the documentation, the request is not supported by the evidence based guidelines. As such, the request for retro (DOS 7/14/14): Omeprazole 20mg #120 is not medically necessary.

Retro (DOS 7/14/14): Ondansetron 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 (Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Antiemetic (for opioid nausea)

Decision rationale: The request for retro (DOS 7/14/14): Ondansetron 8mg #30 is not medically necessary. The Official Disability Guidelines state that Ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. Nausea and vomiting are common with the use of opioids. Side effects tend to diminish over days to weeks of continued exposure. Studies of opioid adverse effects, including nausea and vomiting, are limited to short term duration (less than 4 weeks) and have limited application to long term use. Given the above, the injured worker was not within recommended guideline criteria. Additionally, the submitted documentation lacked any indication of the injured worker suffering from nausea or vomiting. There was no submitted evidence in the report showing how long the injured worker had been taking the Ondansetron. Furthermore, there was no rationale submitted for review to warrant the medication. As such, the request is not medically necessary.

Retro (DOS 7/14/14): 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 Cyclobenzaprine (Flexeril) Page(s): 41.

Decision rationale: The request for retro (DOS 7/14/14): Cyclobenzaprine hydrochloride 7.5mg #120 is not medically necessary. The California MTUS Guidelines recommend Flexeril (Cyclobenzaprine) as an option for short term course of therapy. The greatest effect of this medication is in within the first 4 days of treatment, suggesting that a shorter course may be

better. The submitted documentation lacked the efficacy of the medication, nor was there any submitted evidence showing that the injured worker had any muscle spasm. Furthermore, the request as submitted was for cyclobenzaprine 7.5 mg with a quantity of 120, exceeding the recommended guideline criteria for a short course of therapy. Given the above, the injured worker is not within recommended guideline criteria. As such, the request is not medically necessary.

Retro (DOS 7/14/14): Tramadol 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 Tramadol, Ongoing management Page(s): 82, 93, 94, 113,78.

Decision rationale: The request for retro (DOS 7/14/14): Tramadol ER 150mg #90 is not medically necessary. The submitted documentation did not indicate the efficacy of the medication, nor did it indicate that the Tramadol was helping with any functional deficits the injured worker had. Additionally, there were no assessments submitted for review indicating what pain levels were before, during, and after medication administration. Furthermore, there were no UAs or drug screens submitted for review showing that the injured worker was compliant with prescription medications. Given the above, the injured worker was not within recommended guideline criteria. As such, the request was not medically necessary.

Retro (DOS 7/14/14): Levofloxacin 750mg #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 Infectious Disease

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Drugs.com (Levofloxacin)

Decision rationale: The request for retro (DOS 7/14/14): Levofloxacin 750mg #30 is not medically necessary. ACOEM/MTUS and ODG do not address this request. According to Drugs.com, Levofloxacin is a quinolone antibiotic that fights bacteria. It is used to treat many different types of infection, bacteria, such as tonsillitis, bronchitis, pneumonia, gonorrhea, and infections of the ear, nose, throat, skin, or urinary tract. The medication is also used sometimes together with another antibiotic called clarithromycin to treat stomach ulcers caused by H. pylori infection. Given the above, the injured worker is not within guideline criteria. The submitted documentation did not indicate that the injured worker had any type of infection. Additionally, the request as submitted did not include a frequency or duration of the medication. As such, the request is not medically necessary.