

Case Number:	CM14-0137293		
Date Assigned:	09/05/2014	Date of Injury:	03/30/2012
Decision Date:	10/16/2014	UR Denial Date:	07/30/2014
Priority:	Standard	Application Received:	08/25/2014

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 Pain Management 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 51-year-old male who sustained an injury on March 30, 2012. He is diagnosed with (a) cervicalgia and (b) lumbago. He was seen for an evaluation on July 3, 2014. He complained of frequent pain in the neck with radiation to the upper extremities. The neck pain was rated 5/10. He also reported intermittent pain in the low back with radiation into the lower extremities. The low back pain was rated 4/10. Examination of the cervical spine revealed paravertebral muscle tenderness with spasms. A positive axial loading compression test was noted. His range of motion was limited by pain. Examination of the lumbar spine revealed palpable paravertebral muscle tenderness with spasm. The seated nerve root rest is positive. Standing flexion and extension were guarded and restricted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20 mg #120: Upheld

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

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), Proton pump inhibitors (PPIs)

Decision rationale: The request for Omeprazole 20 mg #120 is not considered medically necessary at this time. From the medical records received, it was determined that omeprazole was prescribed for gastrointestinal symptoms which use would be supported by the Official Disability Guidelines. However, there was no documentation of any complaints of gastrointestinal events secondary to medication intake. Hence, the use of Omeprazole 20 mg #120 is not medically necessary.

Ondansetron 8 mg, #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 (ODG) Pain Chapter

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: Based on the reviewed medical records, this medication was prescribed for nausea as a side effect to cyclobenzaprine and other analgesic agents. There was no documentation of any subjective complaints of nausea secondary to medication intake. More so, the use of this medication is Food and Drug Administration approved only for nausea and vomiting secondary to chemotherapy, radiation treatment, and for postoperative use based on Official Disability Guidelines. As the patient does not have the required condition, the medical necessity of this medication was not established and the request of Ondansetron 8 mg, #30 is not medically necessary and appropriate.

Cyclobenzaprine hydrochloride 7.5mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

Decision rationale: It has been determined that the injured worker has been certified on July 30, 2014 for cyclobenzaprine 7.5 mg #60 for short-term treatment purposes as recommended by the guidelines. Proceeding with the medication, which is recommended by the Chronic Pain Medical Treatment Guidelines for two to three weeks of treatment, is not advised. Hence, the request for Cyclobenzaprine 7.5 mg #120 is not medically necessary at this time.

Tramadol ER 150 mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78 - 80, 93 - 94, and 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 77.

Decision rationale: There was no indication of contraindications for use of first-line medications for pain or whether the injured worker failed a trial of non-opioid analgesics as required by the Chronic Pain Medical Treatment Guidelines. Also, there was lack of documentation of ongoing management of this medication. Therefore, the request for Tramadol ER 150 mg, #90 is not medically necessary and appropriate.