

Case Number:	CM14-0138826		
Date Assigned:	09/18/2014	Date of Injury:	07/07/2014
Decision Date:	10/24/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	08/27/2014

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 Occupational 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 is a 30 year-old male with date of injury 07/07/2014. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 08/06/2014, lists subjective complaints as progressive back pain on the left side with numbness and radiation to the leg. Objective findings: Examination of the lumbar spine revealed tenderness to palpation of the paravertebral muscles and restricted range of motion due to pain. There was positive Patrick-Fabere of the left SI joint. Diagnosis: 1. lumbar spine strain/sprain 2. Lumbar radiculopathy. The medical records provided for review document that the patient was first prescribed the following medications on 07/08/2014. No SIG was provided in the records. Medications: 1. Norco 5/325mg, #202. Percocet 10/325mg, #203. Zofran ODT 4mg, #15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325mg #20 (DOS 7/7/47 & 8/6/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 60.

Decision rationale: The patient has sustained to herniated lumbar discs, L4-5 and L5-S1, both extruding to the left and impinging the adjacent nerve roots. The patient will require some type of pain control until definitive treatment can be rendered. However, the patient was prescribed both Norco and Percocet. According to the MTUS in regard to medications for chronic pain, only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Given the nature of the patient's injury, it is likely he will require stronger of the two opioids. Norco 5/325 is not medically necessary.

Percocet 10/325mg #20 (DOS 8/7/14): Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 80.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. The MTUS states that opioids may be continued, (a) If the patient has returned to work, or (b) If the patient has improved functioning and pain. The patient has had pain relief and functional improvement from the opioids. Percocet 10/325 is medically necessary.

Zofran ODT 4mg #15 (DOS 7/7/14 & 8/6/14): 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), Ondansetron

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), Ondansetron (Zofran)

Decision rationale: There is no documentation that the patient is suffering nausea or vomiting due to any of the approved indications for Ondansetron. Current approved indications include nausea as a result of cancer chemotherapy, radiation of the abdomen or total body radiotherapy, or postoperative nausea/vomiting. Ondansetron not recommended for nausea and vomiting secondary to chronic opioid use. Ondansetron is not medically necessary.