

Case Number:	CM14-0151006		
Date Assigned:	09/19/2014	Date of Injury:	04/01/2014
Decision Date:	12/02/2014	UR Denial Date:	09/10/2014
Priority:	Standard	Application Received:	09/16/2014

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 and is licensed to practice in Connecticut. 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 60-year-old female who reported injury on 04/01/2014. The mechanism of injury was a trip and fall on a reflector and landing on the injured worker's right shoulder. The injured worker had an x-ray of the right shoulder and the humerus, which revealed a displaced fracture of the humeral head. The injured worker was treated with a sling and medications including Temazepam and Norco. The surgical history included an open reduction and internal fixation of the comminuted fracture. Other surgeries were noncontributory. The injured worker underwent postoperative physical therapy. The documentation of 08/18/2014 was for Lidocaine hyaluronic patch 6%/0.2% cream quantity 120. The request was from a pharmacy. There was no Request for Authorization submitted for review for the requested medication. The documentation of 08/06/2014 was a handwritten note, which was illegible. The treatment plan included starting Neurontin 300 mg 3 times a day. The diagnoses included Reflex Sympathetic Dystrophy and right shoulder hemiarthroplasty. The documentation of 08/28/2014 revealed the injured worker's medications included Nalfon 400 mg for chronic pain and inflammation, Cyclobenzaprine for spasms upon examination, Ondansetron 8 mg for nausea associated with headaches, Omeprazole 20 mg for a history of epigastric pain and stomach upset with NSAID use, and Tramadol for severe pain. It further indicated that the use of opioids in the past had decreased similar pain and increased function.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fenoprofen Calcium (Nalfon) 400mg #120: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The California MTUS Guidelines recommend NSAIDs for the short term symptomatic relief of low back pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review failed to provide documented rationale for the use of the medication. There was a lack of documentation indicating the necessity for both a topical and oral form of the NSAID. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Fenoprofen Calcium (Nalfon) 400mg #120 is not medically necessary.

Omeprazole 20mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & cardiovascular risk.

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

Decision rationale: The California MTUS Guidelines indicate that proton pump inhibitors are recommended for injured workers at immediate or high risk for gastrointestinal events. Injured workers with no risk factor or no cardiovascular disease do not require the use of a proton pump inhibitor. The clinical documentation indicated the injured worker had a history of some epigastric pain and stomach upset while using NSAIDs in the past for chronic pain. The duration of use could not be established. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Omeprazole 20mg #120 is not medically necessary.

Ondansetron 8mg #30: 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/medsa601209.html>, 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 Chapter, Ondansetron

Decision rationale: The Official Disability Guidelines indicate that Ondansetron is recommended for injured workers who are postoperative. It is not recommended for nausea associated with chronic pain medication use. The physician documentation indicated the injured worker was prescribed the medication for headache pain with associated nausea. There was a

lack of documentation indicating the injured worker met the criteria for the use of the medication. The documentation indicated the use was for nausea associated with headaches. There was a lack of documented efficacy. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Ondansetron 8mg #30 is not medically necessary.

Cyclobenzaprine Hydrochloride 7.5mg #120: 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 Page(s): 63.

Decision rationale: The California MTUS Guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain. Their use is recommended for less than 3 weeks. The clinical documentation submitted for review indicated the injured worker had palpable muscle spasms during examination. The duration of use could not be established. The request for 120 tablets would exceed guideline recommendations for 3 weeks of use. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Cyclobenzaprine Hydrochloride 7.5mg #120 is not medically necessary.

Tramadol ER 150mg #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain ongoing management Page(s): 60, 78.

Decision rationale: The California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease of pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated that the medication was being prescribed for acute severe pain. The physician documented the dosage was 1 tablet once a day as needed for pain. The documentation indicated the injured worker suffered from an acute exacerbation of severe pain related to a chronic orthopedic condition. The documentation indicated that the use of opioids in the past had decreased similar acute flare ups with the injured worker demonstrating improvement in function. There was, however, a lack of documentation of objective functional improvement, an objective decrease in pain, and documentation of the injured worker being monitored for aberrant drug behavior and side effects. If the patient was being recommended for the medication once a day the request for 90 tablets exceeds the recommended dosing. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Tramadol ER 150mg #90 is not medically necessary.