

Case Number:	CM14-0152177		
Date Assigned:	09/22/2014	Date of Injury:	01/07/2013
Decision Date:	10/30/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/18/2014

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 Internal Medicine and is licensed to practice in California and Illinois. 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 patient is a 57 year old male who was injured on 01/07/2013. The mechanism of injury is unknown. No medication history has been provided. Progress report dated 07/17/2014 states the patient presented with complaints of low back pain that is constant and aggravated by activity. He rated his pain as an 8/10 with radiation into the lower extremities. On exam, there is paravertebral muscle tenderness with spasm. Seated nerve root is positive. Range of motion of the lumbar spine revealed standing flexion and extension are guarded and restricted. There is numbness and tingling in the lateral thigh, anterolateral and posterior leg as well as foot. The patient is diagnosed with lumbago and recommended to continue with medications as per IMR dated 08/25/2014. Prior utilization review dated 08/25/2014 states the request for Nalfon (Fenoprofen Calcium) 400mg one (1) q12hrs #120 is modified to certify Nalon 400 mg #60 for one month supply; Omperazole 20mg one (1) q 12hrs #120; Ondansetron 8mg ODT #30 and Cyclobenzaprine HCL 7.5mg one (1) q8hrs #120 are denied as medical necessity has not been established; Tramadol ER 160mg qd #90 is modified to certify tramadol ER 160 mg #30 for one month supply.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nalfon (Fenoprofen Calcium) 400mg one (1) q12hrs #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-steroidal anti-inflammatory drugs) Page(s): 67-73.

Decision rationale: The guidelines recommend NSAID therapy for acute on chronic pain for short-term treatment. Generally treatment should not exceed 4-6 weeks. It is unclear from the documents how long the patient has been taking NSAIDs. Additionally, from the documents it is not clear if the patient is having significant benefit from NSAID therapy. From the documents provided the indication for NSAID therapy is unclear at this time. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.

Omperazole 20mg one (1) q 12hrs #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 GI symptoms & cardiovascular risk, Page(s): 68-69.

Decision rationale: The guidelines recommend PPI therapy for patients at risk for GI complications on NSAIDs or for patients with certain GI conditions such as dyspepsia, PUD, GERD etc. The guidelines state that PPIs are often over-prescribed without proper indication and the side effect potentials are not properly evaluated by prescribing physicians. The clinical notes did not identify a clear indication for PPI therapy that fits within the current guidelines. It does not appear the patient is at increased risk for GI complications from NSAID use. Additionally, Nalfon was not certified for ongoing use so omeprazole is unnecessary to prevent GI complications. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.

Ondansetron 8mg ODT #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG; Antiemetics (for opioid nausea)

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 opioids nausea)

Decision rationale: The guidelines recommend Ondansetron for treatment of nausea and vomiting secondary to chemotherapy and radiation treatment, in post-operative use, and for acute use in gastroenteritis. From the clinical documents provided it does not appear that the patient does fit within one of the recommended categories for use of Ondansetron. Ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.

Cyclobenzaprine HCL 7.5mg one (1) q8hrs #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (For pain), Page(s): 63-66.

Decision rationale: The guidelines recommend muscle relaxants for short-term use only in acute back pain and muscle spasms. They are generally not recommended for use longer than 4-6 weeks. From the documents provided it appears the patient has been utilizing this medication longer than the recommended duration of therapy. It is not evident that the patient is having a significant benefit from ongoing therapy. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.

Tramadol ER 160mg qd #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids; On-Going Management; When to Disconti.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids, Page(s): 76-96.

Decision rationale: The guidelines recommend chronic opioid therapy for chronic pain for patients who show improved analgesia, improved ADLs/level of functioning, no aberrant behavior, and no significant adverse effects. Additionally, there should be urine drug screening performed to ensure compliance. The interval between urine drug screenings is determined by the patient's risk for substance abuse. The clinical documents provided did not sufficiently demonstrate a significant improvement in analgesia and improved ADLs/functioning. It is also unknown when the patient's previous UDS was and if the findings were consistent with the medication profile. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.