MAXIMUS Federal Services

Case Number:	CM14-0153334		
Date Assigned:	09/23/2014	Date of Injury:	10/23/2002
Decision Date:	10/29/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/19/2014

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 has a subspecialty in Interventional Spine 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 patient is a 51 year old female with an injury date of 10/23/02. The 06/24/14 report by [redacted] states that the patient presents with pain in the neck, lower back, and upper extremity bilaterally in the hands, lower extremity left hip, bilaterally in the knees and ongoing headaches and insomnia associated with pain. Pain is rated 7/10 with medications and 10/10 without. The patient's GERD related, medication associated, GI upset is noted. The patient is currently not working. Lumbar examination reveals spasm in the bilateral paraspinous musculature with tenderness upon palpation in the bilateral paravertebral area L3-S1. Range of motion is moderately limited secondary to pain with straight leg test positive. For the upper extremity, tenderness is noted at the left rotator cuff and left anterior shoulder. The range of motion of the left shoulder was decreased due to pain. The patient's diagnoses include:Chronic painLumbar radiculitisLeft ankle painLeft hip painStatus post bilateral ankle surgery (date unknown)AnxietyDepressionMedication related depressionChronic Nausea and vomiting (04/12/13 report)Current medications as listed as Percocet, Lidoderm, Pantoprazole, Robaxin, and Maxalt. The utilization review being challenged is dated 09/09/14. Reports were provided from 07/13/13 to 06/24/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

1prescription for Ambien 10mg #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG Guidelines Pain Chapter Zolpidem

Decision rationale: The patient presents with pain in the neck, lower back, bilateral upper extremities in the hands, lower extremity left hip, bilaterally in the knees and ongoing headaches and insomnia associated with pain. The treater requests for 1 prescription for Ambien (Zolpidem) 10 mg #30. The reports provided show the patient has been taking this medication since at least 11/15/13. ODG Guidelines Pain Chapter Zolpidem topic state that Ambien) is indicated for short-term treatment of insomnia (usually 2-6 weeks) with difficulty of sleep onset 7 to 10 days. On 06/24/14 the treater states this medication is intended for chronic insomnia and that it has been helpful for sleep quality and duration, and that the patient reports an inability to reduce or discontinue the medication due to severe insomnia. The treater states the plan is to attempt to reduce or discontinue the medication if tolerated. In this case, the efficacy and use of the medication is documented; however, long term use is outside what is allowed by ODG. Therefore the request is not medically necessary.

1 prescription for Naprosyn 500mg #60: Overturned

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 Anti-inflammatory medications Page(s): 22.

Decision rationale: The patient presents with pain in the neck, lower back, bilateral upper extremities in the hands, lower extremity left hip, bilaterally in the knees and ongoing headaches and insomnia associated with pain. The treater requests for Naprosyn 500 mg #60. The reports provided show the patient has been using this medication since at least 11/15/13. MTUS Anti-inflammatory medications page 22 states, "Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted."On 06/24/14 the treater states the medication is beneficial with intended effect at prescribed dose. In this case the use and efficacy of the medication has been documented therefore the request is medically necessary.

1 prescription for Zofran 4mg #60: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines Chronic Pain Chapter for low back regarding Zofran Ondansetron

Decision rationale: The patient presents with pain in the neck, lower back, bilateral upper extremities in the hands, lower extremity left hip, bilaterally in the knees and ongoing headaches and insomnia associated with pain. The treater requests for Zofran (Ondanestron) 4 mg #60. The reports provided show that patient has been using this medications since at least 11/15/13. ODG guidelines have the following regarding Ondansetron: Not recommended for nausea and vomiting secondary to chronic opioid use. It is recommended for chemo-induced or post-operative nausea. On 06/24/14 the treater states this medication has been beneficial with the intended effect. The report further states the medication is used in the treatment of severe nausea of those who have limited response to alternative treatments. In this case, the patient has a diagnosis of severe nausea and vomiting; however, the records provided do not document alternative treatments for this patient. There is no diagnosis of chemo-induced or post operative nausea. The treater does not discuss that nausea is not caused by long term opioid use therefore the request is not medically necessary.

1 prescription for Maxalt 10mg #12: 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 Rizatriptan (Maxalt) Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG-TWC guidelines, Head chapter for Imitrex:

Decision rationale: The patient presents with pain in the neck, lower back, bilateral upper extremities in the hands, lower extremity left hip, bilaterally in the knees and ongoing headaches and insomnia associated with pain. The treater requests for Maxalt 10 mg #12. The reports provided indicate this medication has been used since at least 04/29/14. ODG guidelines Rizatriptan (Maxalt) Topic states that the medication is recommended for migraine headaches. The treater notes that this medication is for headaches; however, it is not stated that is it beneficial to the patient or the use is intended for migraine headaches. There is no discussion or diagnosis of migraine headaches. MTUS page 60 states that "Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity."Lacking documentation of the efficacy and use of this medication therefore the request is not medically necessary.

1 prescription for Glucosamine/Condroit DS Tb 500-400mg #60: 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 Glucosamine (and Chondroitin Sulfate) Page(s): 50.

Decision rationale: The patient presents with pain in the neck, lower back, bilateral upper extremities in the hands, lower extremity left hip, bilaterally in the knees and ongoing headaches and insomnia associated with pain. The treater requests for Glucosamine chondroitin DS Tb 500-400 mg#60. The reports provided show the patient has been taking this medications since at least 04/12/14. MTUS guidelines Glucosamine (and Chondroitin Sulfate) page 50 state that this medication is recommended as an option in patients with moderate arthritis pain, especially for knee osteoarthritis. 04/12/13 the treater states the medication is a supplement provided for chronic pain to limit pathophysiologic changes related to osteoarthritis. The treater does not state the medication has been of benefit to the patient. In this case there is no diagnosis or discussion of osteoarthritis in this patient; however, examination does show pain in the knees. Lacking a diagnosis of arthritis pain therefore the request is not medically necessary.