MAXIMUS Federal Services

Case Number:	CM14-0162620		
Date Assigned:	10/07/2014	Date of Injury:	08/25/2013
Decision Date:	11/10/2014	UR Denial Date:	10/02/2014
Priority:	Standard	Application Received:	10/03/2014

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 Anesthesiologist, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 40-year-old male who reported an injury on 08/25/2013. Mechanism of injury was not provided. The injured worker has a diagnoses of cervical strain, left shoulder strain, and left shoulder impingement. The past medical treatment included medications, physical therapy, and shoulder injections (date was not provided). Diagnostic testing included an MRI of the cervical spine on 12/16/2013, and an MRI of the left shoulder on 12/16/2013. No pertinent surgical history. The injured worker complained of pain radiating from the neck into the left arm, and it was associated with numbness and weakness, on 08/28/2014. The injured worker rated his pain a 9/10 without medications, and 7/10 with medications. The injured worker stated he was having spasms in his neck and shoulder, which are decreased with a muscle relaxant. The physical examination revealed normal reflex, sensory and power testing to bilateral upper and lower extremities, except for numbness and weakness on the left at C6. Posterior cervical and left shoulder tenderness with posterior spasms in the musculature. The cervical spine range of motion decreased 40%. Mild left shoulder impingement. Medications were not provided. The treatment plan is for Zofran 8 mg quantity #10 dispensed 09/25/2014, and Doral quazepam 15 mg quantity #30 dispensed 09/25/2014. The rationale for the request was not submitted. The Request for Authorization form was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zofran ondanset 8mg, QTY: 10.00, dispensed 9/25/14: 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), Pain

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

Decision rationale: The injured worker complained of pain radiating from the neck into the left arm, and it was associated with numbness and weakness, on 08/28/2014. The Official Disability Guidelines state Ondanset (Zofran) is not recommended for nausea and vomiting secondary to chronic opioid use. There is lack of documentation the injured worker is on an opioid or had nausea/vomiting symptoms. The frequency of the requested medication was not provided. The guidelines do not support the request. Therefore the request for Zofran (ondanset) 8mg, QTY: 10.00, dispensed 9/25/14 is not medically necessary.

Doral Quazepam 15mg, QTY: 30.00, dispensed 9/25/14: 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), Pain, Benzodiazepines

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

Decision rationale: The injured worker complained of pain radiating from the neck into the left arm, and it was associated with numbness and weakness, on 08/28/2014. The Official Disability Guidelines (ODG) state Recommend that treatment be based on the etiology, with the medications recommended below. See Insomnia. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Benzodiazepines: FDA-approved benzodiazepines for sleep maintenance insomnia include estazolam (ProSom), flurazepam (Dalmane), quazepam (Doral), and temazepam (Restoril). Triazolam (Halcion) is FDA-approved for sleep-onset insomnia. These medications are only recommended for short-term use due to risk of tolerance, dependence, and adverse events (daytime drowsiness, anterograde amnesia, next-day sedation, impaired cognition, impaired psychomotor function, and rebound insomnia). These drugs have been associated with sleep-related activities such as sleep driving, cooking and eating food, and making phone calls (all while asleep). Particular concern is noted for patients at risk for abuse or addiction. Withdrawal occurs with abrupt discontinuation or large decreases in dose. Also characterized by impairment in daily function due to sleep insufficiency. These impairments include fatigue, irritability, decreased memory, decreased concentration, and malaise. There is no documentation stating the injured worker has a diagnosis of Insomnia. There is lack of documentation the injured worker has any sleep disturbance, or difficulty in sleep initiation or maintenance, and/or early awakening. There is lack of documentation of any characterized impairment. The frequency of the requested medication was not provided or the length of treatment with this medication.

Therefore the request for Doral Quazepam 15mg, QTY: 30.00, dispensed 9/25/14 is not medically necessary.

Ultram tramadol hcl 150mg, QTY: 60.00, dispensed on 9/25/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 113.

Decision rationale: The California MTUS guidelines recommend ongoing review with documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain, the least reported pain over the period since last assessment, average pain, and intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The guidelines also recommend providers assess for side effects and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. The requesting physician did not provide documentation of an adequate and complete assessment of the injured worker's pain. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. Therefore the request for Tramadol is not medically necessary.