

Case Number:	CM14-0162826		
Date Assigned:	10/08/2014	Date of Injury:	12/26/2005
Decision Date:	11/10/2014	UR Denial Date:	09/08/2014
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 Family Practice, has a subspecialty in Primary Care Sports Medicine and is licensed to practice in Florida, Ohio, and Texas. 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 42-year-old male with a reported date of injury on 12/06/2005. The injury reportedly occurred during a bicycle accident. His diagnoses were noted to include lumbar disc displacement, hand joint pain, and wrist pain. His previous treatments were noted to include physical therapy and medications. The progress note dated 08/07/2014 revealed complaints of pain to the low back rated 7/10. The injured worker also complained of constant pain to the right wrist that was aggravated by repetitive motions rated 7/10. The physical examination of the right wrist/hand revealed tenderness at the dorsal aspect of the right wrist. There were positive Tinel's and Phalen's signs. There was a limited range of motion and no clinical evidence of instability. The physical examination of the lumbar spine revealed palpable paravertebral muscle tenderness with spasms and the seated nerve root test was positive. There was limited range of motion and no clinical evidence of instability. The sensation and strength tests were within normal limits. The Request for Authorization form dated 09/03/2014 was for 120 Omeprazole 20 mg as needed for stomach upset, 30 Ondansetron 8 mg as needed for stomach upset/nausea, 100 cyclobenzaprine HCl 7.5 mg as needed for muscle spasm, and 90 tramadol ER 150 mg as needed for severe pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The request for Omeprazole 20mg #120 is not medically necessary. The injured worker has been utilizing this medication since at least 11/2009. The California Chronic Pain Medical Treatment Guidelines state clinicians should determine if the injured worker is at risk for gastrointestinal events which include age greater than 65 years; history of peptic ulcer, gastrointestinal bleeding or perforation; concurrent use of aspirin, corticosteroids, and/or an anticoagulant; or using high dose/multiple NSAIDs. There is a lack of documentation regarding efficacy of this medication. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request 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 Official Disability Guidelines, Pain (chronic) Ondansetron (Zofran)

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

Decision rationale: The request for Ondansetron 8mg #30 is not medically necessary. The injured worker has been utilizing this medication since at least 08/2014. The Official Disability Guidelines do not recommend antiemetics for nausea and vomiting secondary to chronic opioid use. Antiemetics are recommended for acute use and nausea/vomiting is common with the use of opioids. Ondansetron is FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA approved for postoperative use and gastroenteritis. There is a lack of documentation regarding efficacy of this medication. The guidelines state it is only FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment, postoperative use, and gastroenteritis. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

Cyclobenzaprine HCL 7.5mg #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 request for Cyclobenzaprine HCL 7.5mg #120 is not medically necessary. The California Chronic Pain Medical Treatment Guidelines recommend muscle

relaxants with caution as a second-line option for short term treatment of acute exacerbations of chronic low back pain. Cyclobenzaprine is not recommended for use beyond 2 to 3 weeks. The injured worker has been utilizing this medication since at least 08/2014. There is a lack of documentation regarding objective functional improvement with utilization of this medication. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

Tramadol ER 150mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

Decision rationale: The request for Tramadol ER 150mg #90 is not medically necessary. The injured worker has been utilizing this medication since at least 02/2013. According to the California Chronic Pain Medical Treatment Guidelines, the ongoing use of opioid medications may be supported with detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines also state that the 4 A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors should be addressed. There is a lack of documentation regarding evidence of decreased pain on a numerical scale with the use of this medication. There is a lack of documentation regarding improved functional status, side effects, and as to whether the injured worker has had consistent urine drug screens and when the last test was performed. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.