

<b>Case Number:</b>	CM14-0166866		
<b>Date Assigned:</b>	10/14/2014	<b>Date of Injury:</b>	09/29/2011
<b>Decision Date:</b>	11/18/2014	<b>UR Denial Date:</b>	09/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/09/2014

### 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 59-year-old male with a date of injury of 09/29/2011. The listed diagnoses per [REDACTED] are: 1. Lumbago. 2. Pain in hips/pelvis. According to progress report 07/21/2014, the patient presents with low back pain with radiation of pain into the lower extremities with associated tingling and numbness. The patient rates his pain a 6/10 on a pain scale. Examination revealed palpable paravertebral muscle tenderness with spasm and seated nerve root test is positive. Range of motion in standing flexion and extension are guarded and restricted. Examination of the right hip revealed tenderness at the anterior lateral aspect of the right hip with painful hip rotation. Request for authorization from 09/03/2014 states that this is a request from date of service of 07/21/2014. It was noted that "meds not dispensed". Treater is requesting Omeprazole 20 mg, Ondansetron 8 mg, Cyclobenzaprine 7.5 mg, and Tramadol ER 150 mg. Utilization review denied the request on 10/03/2014. Treatment reports from 01/06/2014 through 08/04/2014 were reviewed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Omeprazole 20 mg #120:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitor Page(s): 68-69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68-69.

**Decision rationale:** This patient presents with low back and hip pain. The treater is requesting Omeprazole 20 mg #120. The treater is requesting Omeprazole for patient's GI symptoms. The MTUS Guidelines page 68 and 69 states that Omeprazole is recommended with precaution for patients at risk for gastrointestinal events: (1) Age is greater than 65, (2) History of peptic ulcer disease and GI bleeding or perforation, (3) Concurrent use of ASA or corticosteroid and/or anticoagulant, (4) High dose/multiple NSAID. Review of the medical file indicates the patient has been taking Voltaren SR 100 mg on a long-term basis. The treater is requesting Omeprazole 20 mg for patient's "GI symptoms and to continue to protect her stomach and prevent GI complications." Utilization review states that this medication is reasonable and modified the certification from the requested #120 to #60. In this case, the patient has been taking NSAID on a long-term basis and the treater states that the patient has GI symptoms. Given such, the request is medically necessary.

**Ondansetron 8 mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): Pain : Ondansetron (Zofran)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**Decision rationale:** This patient presents with continued low back and hip pain. The treater is requesting Ondansetron 8 mg #30 for "nausea associated with headaches that are present with chronic cervical spine pain." Treater states that the patient's headache pain is associated with nausea and "in fact, Ondansetron has been proven to be very effective with treating this particular type of nausea." The MTUS and ACOEM Guidelines do not discuss Zofran; however, ODG Guidelines under its pain section has the following regarding antiemetic, "Not recommended for nausea and vomiting secondary to chronic opiate use. Recommended for acute use as noted below for FDA-approved indications. Ondansetron (Zofran), this drug is a serotonin 5-HT<sub>3</sub> receptor antagonist. It is FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA approved for postoperative use." In this case, the treater has been prescribing Ondansetron on a long-term basis for patient's continued nausea associated with headaches. The ODG Guidelines do not support the use of Ondansetron other than for postoperative use. The request is not medically necessary.

**Cyclobenzaprine Hydrochloride tablets 7.5 mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics Page(s): 63, 64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 64.

**Decision rationale:** This patient presents with low back and hip pain. The treater is requesting Cyclobenzaprine 7.5 mg #120. It is unclear how long this patient has taken this medication as the treater does not provide treatment history regarding Cyclobenzaprine. Request for authorization from September 2014 indicates the "medication has not yet been dispensed" and the treater requested Cyclobenzaprine 7.5 mg #120. The MTUS Guidelines page 64 states that Cyclobenzaprine is recommended for short course of therapy. Limited mixed evidence does not allowed for recommendation for chronic use. The treater has prescribed this medication for long-term use, which is not recommended by MTUS. The request is not medically necessary.

**Tramadol ER 150 mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 76-78, 93-94.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 88 and 89, 78.

**Decision rationale:** This patient presents with low back and hip pain. The treater is requesting Tramadol ER 150 mg #90 for patient's acute severe pain. The MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4 A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. Review of the medical file does not include treatment history of this medication. It is unclear when this medication was first prescribed. In this case, the treater states in his report 08/04/2014, "The use of opioids in the past has decreased similar acute flare-ups with the patient demonstrating improvement in function." The patient has taken opioid in the past and treater does not discuss its efficacy. There is no discussion of functional improvement, changes in ADLs as required for long-term opiate use. Furthermore, the treater has not provided discussion regarding possible side effects and urine drug screens were not provided for review. Given the lack of sufficient documentation for opiate management, the request is not medically necessary.