

Case Number:	CM14-0026847		
Date Assigned:	06/13/2014	Date of Injury:	08/22/2007
Decision Date:	07/16/2014	UR Denial Date:	02/24/2014
Priority:	Standard	Application Received:	03/03/2014

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 Physical Medicine and Rehabilitation, and Pain Medicine, and is licensed to practice in 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 53 year old male injured on 8/22/07 due to an undisclosed mechanism of injury. Current diagnoses included cervical radiculopathy, lumbar radiculopathy, depression, iatrogenic opioid dependency, insomnia, status post right shoulder surgery, multiple emergency room visits, and chronic nausea vomiting. A clinical note dated 2/4/14 indicated that the injured worker presented complaining of neck pain radiating down the right upper extremity, low back pain radiating down the bilateral lower extremities, and upper extremity pain in addition to bilateral shoulder pain. The injured worker rated his pain 7-8/10 with medications and 10/10 without. The injured worker also reported medications allowed for functional improvement, including the ability to attend church, bathe, care for his pets, improve concentration, cooking, shopping, etc. He reported an overall improvement in quality of life, decreased pain, and increased level of function. Physical examination revealed slow gait with utilization of a cane, spasm of lumbar spine, tenderness to palpation in the spinal vertebral area at L4-S1, decreased range of motion in the lumbar spine moderately limited secondary to pain, and tenderness in the left knee. The injured worker was administered a Toradol and B12 intramuscular injection during the office visit. Current medications included Restone 3-100mg every night, Dilaudid 2mg every eight hours, MS Contin 30mg every eight hours, Trazadone 50mg every night, gabapentin 600mg three times a day, hydrocodone/acetaminophen 10-325mg every four hours, Ondansetron 4mg every day, cyclobenzaprine 7.5mg three times a day, and omeprazole 20mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

RESTONE 3-100MG #30, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drugs.com.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, and Drugs.com.

Decision rationale: As noted in the pain chapter of the Official Disability Guidelines, the use of herbal medicines or medical foods is not recommended. Restone is the trade name for melatonin/l-tryptophan. It is utilized in the treatment of sleep problems, jet lag, anxiety or depression, and boosting the immune system. There is no indication the injured worker has failed previous prescription medications or has obvious contraindications that necessitate medical food/herbal use. As such, the request is not medically necessary.

DILAUDID 2MG TABLET #90: 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 Page(s): 77.

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is sufficient documentation regarding the functional benefits and functional improvement obtained with the continued use of narcotic medications. In addition, opioid risk assessments regarding possible dependence or diversion were also discussed. As the clinical documentation provided for review supports an appropriate evaluation for the continued use of narcotics as well as establishes the efficacy of narcotics, the request is medically necessary.

HYDROCODONE 10/325MG #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82-88.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 77.

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is sufficient documentation regarding the functional benefits and functional improvement obtained with the continued use of narcotic medications. In addition, opioid risk assessments regarding possible dependence or diversion were also discussed. As the clinical documentation provided for review supports an

appropriate evaluation for the continued use of narcotics as well as establishes the efficacy of narcotics, the request is medically necessary.

ONDANSETRON 4MG #30, #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: As noted in the pain chapter of the Official Disability Guidelines, antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. Zofran is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use and acute gastroenteritis. There is no documentation of previous issues with nausea or an acute diagnosis of gastroenteritis. Additionally, if prescribed for post-operative prophylaxis, there is no indication that the injured worker has previously suffered from severe post-operative nausea and vomiting. Additionally, the medication should be prescribed once an issue with nausea and vomiting is identified, not on a prophylactic basis. As such, the request is not medically necessary.

CYCLOBENZAPRINE 7.5MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Muscle relaxants (for pain) Page(s): 63.

Decision rationale: As noted on page 63 of the Chronic Pain Medical Treatment Guidelines, muscle relaxants are recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the injured worker has exceeded the 2-4 week window for acute management also indicating a lack of efficacy if being utilized for chronic flare-ups. As such, the request is not medically necessary.