

Case Number:	CM14-0029425		
Date Assigned:	06/20/2014	Date of Injury:	06/18/2013
Decision Date:	08/12/2014	UR Denial Date:	02/07/2014
Priority:	Standard	Application Received:	03/07/2014

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 Orthopedic Surgery 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 64-year-old female who reported an injury on 06/18/2013. The mechanism of injury was not provided for review. The injured worker reportedly sustained an injury to her low back which was recalcitrant to conservative measures and ultimately resulted in lumbar decompression surgery. The injured worker's postsurgical pain was managed with medications. A request for authorization for medications was made on 12/04/2013. Naproxen sodium was requested to assist with signs and symptoms of chronic pain. A request for Cyclobenzaprine was made to assist with acute exacerbations of pain and spasming. A request for Sumatriptan was made to assist with migraine pain control. A request for Ondansetron was made to assist with possible nausea related to the use of Cyclobenzaprine. A request was made for Omeprazole to relieve epigastric pain related to the use of Naproxen. A request for Tramadol was made to assist with pain control. The injured worker was evaluated on 12/17/2013. It was noted that the injured worker continued to complain of the cervical spine, bilateral shoulders, lumbar spine, and bilateral hips as painful. Physical findings included reproducible pain including decreased sensation and pain in the L5 nerve root distribution of the bilateral lower extremities with restricted, painful range of motion of the cervical spine, lumbar spine, bilateral hips and bilateral shoulders. The injured worker's diagnoses included cervical discopathy, lumbar discopathy, carpal tunnel/double crush syndrome, possible hip internal derangement, and possible internal derangement of the shoulders. The injured worker's treatment plan included continued use of medications for symptom control.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ondansetron ODT tablets 8mg #30 times two for nausea: 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 Chapter, Antiemetics (for opioid nausea).

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

Decision rationale: The requested Ondansetron ODT tablets 8 mg #30 2 times for nausea is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this medication. Official Disability Guidelines do not support the use of antiemetics to treat side effects related to medication usage. The clinical documentation submitted for review does not provide any evidence of acute gastritis which would benefit from the use of this medication. Additionally, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Ondansetron ODT tablets 8 mg #30 x 2 for nausea is not medically necessary or appropriate.

Cyclobenzaprine Hydrochloride tablets 7.5mg #120 for spasms: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain). Decision based on Non-MTUS Citation American Family Physician.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The requested Cyclobenzaprine Hydrochloride tablets 7.5 mg #120 for spasms is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend the long term use of muscle relaxants in the management of chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been taking this medication since at least 08/2013. This exceeds a short duration of treatment recommended by guidelines not to exceed 2-3 weeks. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. Furthermore, the request as it is submitted does not clearly identify frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request for Cyclobenzaprine Hydrochloride tablets 7.5 mg #120 for spasms is not medically necessary or appropriate.

Tramadol Hydrochloride ER 150mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids.

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

Decision rationale: The requested Tramadol Hydrochloride extended release 150 mg #90 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the continued use of opioids in the management of chronic pain be supported by documented functional benefit, a quantitative assessment of pain relief, evidence that the injured worker is monitored for aberrant behavior and manage side effects. The clinical documentation submitted for review does not provide a quantitative assessment of pain relief to support continued use of this medication. Additionally, there is no documentation of functional benefit or that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 08/2013. Therefore, a treatment history to include pain relief and functional benefit should be established. Furthermore, the request as it is submitted does not clearly identify the frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Tramadol Hydrochloride ER 150 mg #90 is not medically necessary or appropriate.

Terocin patch Quantity: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The requested Terocin patch quantity 30 is not medically necessary or appropriate. The requested medication contains Capzasin, Menthol, and Methyl Silicate. The California Medical Treatment Utilization Schedule does not support the use of Capzasin as a topical analgesic unless there is documentation that the injured worker has failed first line treatments. There is no documentation that the patient has failed to respond to first line medications to include antidepressants or anticonvulsants. Therefore, the use of this medication would not be supported. Additionally, the request as it is submitted does not provide a dosage or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Terocin patch quantity 30 is not medically necessary or appropriate.